MARYLAND
STATE MEDICAL JOURNAL

JANUARY 1972



SUBURBAN HOSPITAL
BETHESDA

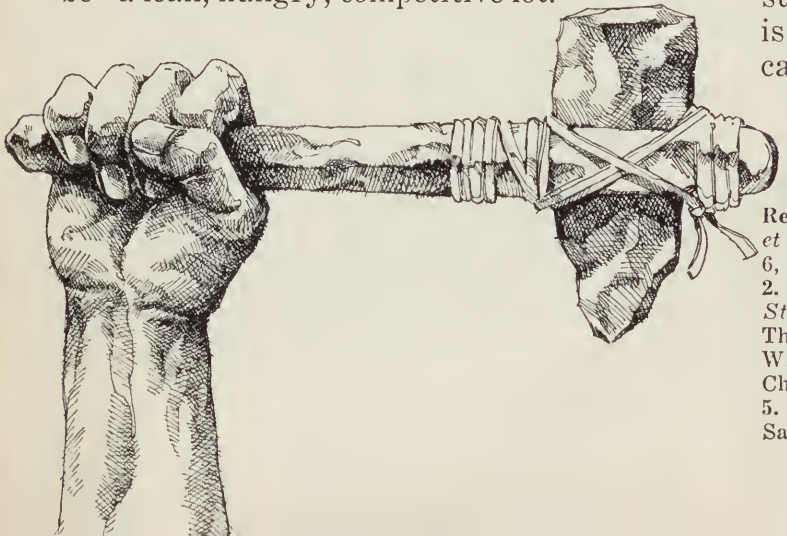
# IF MORE MEN CRIED



**At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]**

**Hypersecretion—an atavistic response.** Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

**By chance? A lean, hungry lot.** Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



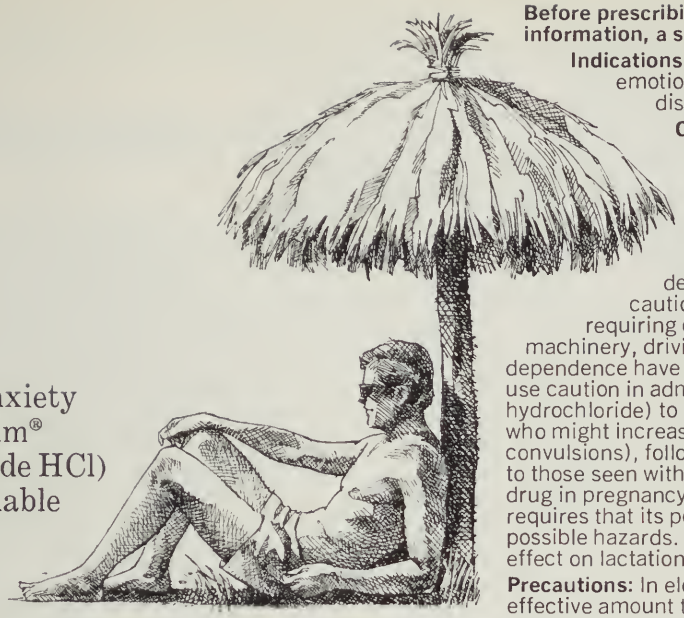
**Big boys don't cry.** If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstadt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, he is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



**Take away stress, you can take away symptoms.** There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

**The rest cure vs. the two-way action of Librax.®** For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that con-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. I., *et al.* (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 114. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstadt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 63. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W.B. Saunders Company, 1951, p. 384.



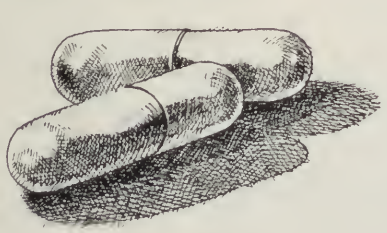
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**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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VOLUME 21 JANUARY 1972 NUMBER 1


## ARTICLES:


**Alexander Hamilton, Dr. Alexander Hamilton's Defense of Dr. Thomson's Discourse on the Preparation of the Body for the Smallpox,** Douglas G. Carroll, MD ..... 55

This is the third of a ten-part series of articles on the history of medicine in Maryland.

**The Late Apical Systolic Murmur,** Joseph W. Linhart, MD ..... 61

Evidence has accumulated that an apical systolic murmur confined to the latter part of systole, unrelated to coronary disease, is not necessarily benign or functional in nature. It may arise from the mitral valve and its supporting structures, be associated with a characteristic deformity of the mitral valve, be associated with mild to moderate late mitral regurgitation, and not necessarily be benign in clinical course.

**Treatment of the Alcoholic and the Family** ..... 67

This panel-symposium, moderated by Martin L. Singewald, MD, was presented during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. It was mainly designed for clergymen and lay people.


## DEPARTMENTS:


**Rehabilitation Medicine—What is Physical Medicine and Rehabilitation?** ..... 15

**Your Medical Faculty at Work,** John Sargeant ..... 16

**Maryland Medical Political Action Committee** ..... 20

**Alcoholism Section—Children of Alcoholics—A Hidden Tragedy,** Willem G. H. Bosma, MD ..... 34

**Baltimore City Health Department—Staff Notes** ..... 38

**Heart Page—Electrical Safety and the Heart Patient,** William S. Staewen, ScB 45

**Maryland State Department of Health and Mental Hygiene—Viral Upper Respiratory Diseases,** Howard J. Garber, MD; T. A. Dadisman, Jr., MD .... 47

**Library—How Does Your Library Stack Up?; New Accessions** ..... 51



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ON THE COVER: This aerial view of the Suburban Hospital in Bethesda is by Brooks Photographers.

## MISCELLANY:


Doctors in the News **5**

Medical News Briefs **8**

Executive Director's Newsletter **11**

Emergency Department Symposium News **17**

Doctors Take Note **18**

Revised Immunization Recommendations **25**

American Association of Medical Assistants **27**

Book Reviews **30**

1972 Semiannual Meeting News **33**

Scientific Exhibit Form **39**

Component Society News **49, 91**

Woman's Auxiliary **87**

Letters to the Editor **93**

MEDIC **96**

Art & Hobby Exhibit Form **97**

Classified Advertising **99**

Advertising Index **100**

Annual Meeting News **Cover 3**

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2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
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Med-Chi Salutes

## SUBURBAN HOSPITAL

In the second of a continuing series, we salute the Suburban Hospital this month. It is located at 8600 Old Georgetown Road in Bethesda, Maryland.

The 350-bed acute general hospital was established by the community in 1943 and operates on a voluntary nonprofit basis.

It has no religious or political influences and cares for patients without regard to race, color, or creed.

It has a graduate training program for interns and residents.

The Montgomery College Associate Degree Program in Nursing has an affiliation with Suburban. An accredited School of Practical Nursing and ongoing and inservice educational programs are conducted by the Nursing Department.

There are more than 300 physicians on the active staff and 400 members on the courtesy staff.

The Outpatient Department has 17 clinics serving the medically indigent.

The Board of Trustees of the Suburban Hospital Association is the governing body. Mrs. Amelia C. Carter is the Administrator.

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# Doctors in the News



Dr. Laughlin

**Henry P. Laughlin,** MD, of Bethesda, was recently elected to the prestigious office of president of The American College of Psychoanalysts, a national honorary professional organization which recognizes and honors selected physician-analysts.

Dr. Laughlin is an internationally known clinician, teacher, and author in psychiatry and psychoanalysis. Since 1941, he has been in private practice in Bethesda.

Earlier in his career, he served in World War II as a Lieutenant Commander with the U. S. Navy Medical Corps. He has since held major positions as a consultant in psychiatry, training, research, and administration with a number of U. S. government agencies. He has been a visiting professor of psychiatry at leading universities around the world and has been associate clinical professor of psychiatry at the George Washington University Medical School for many years.

Dr. Laughlin has published more than 80 scientific papers and authored a number of textbooks in psychiatry. He served as president of the Eastern Psychoanalytic Association from 1962 to 1964 and of The American College of Psychiatrists from 1963 to 1965. Dr. Laughlin has received numerous awards and honorary citations for his professional achievements and contributions.

•

**Henry L. Burke,** MD, of Charles County, has been named a Diplomate of the American Board of Internal Medicine.

**Robert T. Singleton,** MD, Baltimore, has been chosen to represent Maryland as councilor on the governing body of the Southern Medical Association. The appointment came at the group's recent 65th annual meeting in Miami Beach.

•

At the recent annual meeting of the Maryland Heart Association, **Donald H. Dembo,** MD, Baltimore, was elected president. **Robert J. Wilder,** MD, Baltimore, was installed as president-elect, and **Jason Geiger,** MD, Montgomery County, was reelected vice-president. Doctors elected or reelected to the Board of Trustees include **Vincent J. Fiocco, Barton J. Gershen, Paul E. Huffington,** and **John H. Hornbaker.**

•

**Russell A. Nelson,** MD, president, Johns Hopkins Hospital, has been named the chairman of the Association of American Medical Colleges. He is the first individual who is not a medical school dean to achieve the highest elective office in the association. The AAMC represents 104 medical schools and 387 teaching hospitals with associated members in several countries.

Dr. Nelson became director of The Johns Hopkins Hospital in 1952, executive vice-president in 1958, and president in 1963. A 1933 graduate of the University of Minnesota, he received his MD degree from Hopkins in 1937. Since then, his entire professional life has been spent at Hopkins where, between 1937 and 1944, he served successively as intern, assistant resident, and resident in medicine.

**William W. Pope,** MD, has been appointed deputy state and county health officer for Garrett County. A native of San Francisco, Dr. Pope received his BA and MD degrees from Stanford University, and his MPH from The Johns Hopkins School of Hygiene and Public Health. He comes to Garrett County from Baltimore where he was medical director of a Neighborhood Health Center for Provident Hospital.

•

The appointment of **Derek Von Roemer,** MD, as director for Region II, comprising Baltimore, Harford, and Carroll counties, has been announced by the Maryland Department of Health and Mental Hygiene's Drug Abuse Administration. Dr. Roemer will oversee the administration's educational and treatment activities in these areas. In addition, he will continue to serve in a dual capacity as chief of the Baltimore County Health Department's Division of Comprehensive Drug Abuse.

•

**Stuart L. Nightingale,** MD, has been appointed medical director in the Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene. He will be responsible for the medical aspects of drug abuse including treatment, counseling, and abstinence programs and will work closely with the administration's director, Philip Greene, in setting medical policies, guidelines, regulations, and determining medical standards for each program. He had been serving as research program manager of the Health Service Research and Development Center of The Johns Hopkins Medical Institutions since 1970.

**Henry A. Briele,** MD, Salisbury, has been elected to the Board of Governors of the American College of Surgeons to represent the State of Maryland. He will serve a three-year term and was elected at the recent annual Clinical Congress of the College held in Atlantic City. Governors act as communication links between the 32,000 Fellows of the College and headquarters staff.

•

**Jesse R. Liscomb,** MD, Annapolis, was recently certified as a Fellow of the American College of Anesthesiologists.

•

At the annual meeting of the Washington County Medical Society in November, **Ralph H. Williams,** MD, was elected president, succeeding **Sidney Novenstein,** MD. The new president-elect is **Edson B. Moody,** MD. Also elected at the meeting were: **Charles C. Spencer,** vice-president; **Francisco G. Japzon,** MD, secretary; and **Frank E. Brumback,** MD, treasurer. The 1972 Med-Chi delegate will be **A. Maynard Bacon,** MD, with **Harold H. Gist,** MD, serving as alternate. **John A. Moran,** MD, was elected chairman of the Board of Censors.

•

**Harvey Webb,** MPH, became director of the Provident Comprehensive Neighborhood Health Center in Baltimore in late November. The center provides comprehensive care for about 5,000 children and adults. The Provident project has particular importance because it is a joint venture of community residents and the local and federal governments.

At Johns Hopkins, Dr. Webb has been assistant professor in the departments of Public Health Administration and Medical Care and Hospitals in the School of Hygiene and Public Health.

Dr. Webb received three academic degrees from Howard University: BS in 1956, DD in 1960, and MS in 1962. Johns Hopkins awarded him his MPH in 1967.

•

The Sheppard and Enoch Pratt Hospital in Towson announces the following appointments, honors, and awards:

**Robert W. Gibson,** MD, medical director, has been elected treasurer of the Maryland Health Maintenance Committee. **Irvin H. Cohen,** MD, director of residency training, has been appointed a member of the Executive Council of the Maryland Hospital Association. **Emilio J. Dominquez,** MD, Adolescent Unit director, has been elected a full member of the American Association for Children's Residential Centers. **Facundo P. Lima, MD,** has joined the medical staff as a staff psychiatrist.

## Did You Know?

- There are about 7,000 drugs now being offered the consumer today—200 of them accounting for about 65% of all prescriptions.
- The average American uses 4 to 5 prescriptions a year.
- The average family requires about 14 to 16 prescriptions annually.
- Consumption of prescription drugs and medicines has been increasing rapidly in the United States since the end of World War II, and there is every indication that this use will continue.



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# Medical News Briefs

## NEW DAY CARE CENTER RULES ARE ADOPTED

Effective December 1, a new set of regulations governing day care centers for children was adopted by the Maryland Department of Health and Mental Hygiene.

Four particular areas have been under careful scrutiny, and the new regulations reflect these concerns.

First, the minimum age, which had been one year, has been upped to two years.

Second, the minimum playspace required per child became 35 square feet, up from 30. However, those facilities already licensed may continue at the old rate.

Third, the child-to-staff ratio is now a maximum of one adult to 13 five-year-old children, one adult to ten three-and-four-year olds, and one adult to six children who are two years of age.

Fourth, staff qualifications are set down for the number of children for which the facility is licensed. A minimum age of 21 is required, except for aides. In centers licensed before adoption of the new regulations, staff personnel must continue their education to meet the new standards. This upgrading must be completed within three years.

Persons desiring copies of "Regulations Governing Group Day Care Centers," may obtain them through their local health department or from the Division of Maternal and Child Health, Department of Health and Mental Hygiene, State Office Building, 301 West Preston Street, Baltimore, Md. 21201.



HOSPITAL AWARD—Luis G. Martin, MD, (center) Ellicott City, received the St. Agnes Hospital Department of Medicine's award for outstanding contributions toward patient care and medical education. Presentation was made by Emidio A. Bianco, MD, (2nd from l) the hospital's medical director. The plaque was held by Emile R. Mohler, Jr., MD, chairman of the hospital's Department of Medicine. Also participating in the ceremony were Thomas B. Connor, MD, (2nd from r) director of clinical studies center for the University of Maryland Hospital, and Lewis P. Gundry, MD, of the St. Agnes Hospital attending staff. Mr. Martin, the first recipient of this award, serves as consultant in endocrinology to the St. Agnes Hospital medical staff.



LIVE SAVERS—Coronary care training course registered nurses Jeanette Spivey, Mt. Wilson Hospital; Doris Owen, Mercy Hospital; Lisa Arlotti, Johns Hopkins Hospital; and Marilyn Branning, University Hospital, become familiar with monitoring equipment in the coronary care unit of South Baltimore General Hospital, under the tutelage of supervisor Mrs. P. Larrimore. The course, sponsored by the Maryland Regional Medical Program and the University of Maryland School of Nursing, is being taken by nurses from all parts of Maryland.

## VD TASK FORCE

In action designed to sweep away shadows enveloping the crucial health problem of venereal disease, the Maryland Health and Mental Hygiene secretary, Neil Solomon, MD, has formed a VD Task Force. He has charged it with reviewing the problem in Maryland and presenting him with preventive and control methods within six months.

The task force will be headed by John C. Hume, MD, dean of the School of Hygiene and Public Health, The Johns Hopkins University. Dr. Hume is a member of the national HEW commission charged with the same responsibility.

Other members include physicians, county health officers, legislators, members of PTA and service clubs, and college and high school students.

Gonorrhea is now Maryland's number one reported communicable disease with more than 15,000 cases being reported during 1970. There were 441 cases of infectious syphilis logged for the same period. It is estimated that only 20% of gonorrhea cases and 85% of syphilis cases are ever reported, thus making the task force's responsibility critical and imperative, according to Dr. Solomon.

## SHEPPARD PRATT OPENS NEW CENTRAL BUILDING

The Sheppard and Enoch Pratt Hospital in Towson officially opened the doors to its new Central Building in dedicatory services on October 19.

Bertram S. Brown, MD, director of The National Institute of Mental Health, was the main speaker. Bliss Formush, MD, honorary president of the Board of Trustees dedicated the building, located between and adjoining the hospital's original A and B Buildings.

The Central Building includes professional offices, patient treatment offices, conference rooms, administrative offices, new kitchens, dining rooms, a new library, museum area, and also provides for a new heating and cooling plant. Final construction cost is estimated at $2.5 million.

Before the opening, Robert W. Gibson, MD, who has been medical and executive director of the hospital since 1963, stated, "When the new building opens its doors, the projected second phase will begin to involve further renovation of existing hospital areas."

## RADIOLOGY GIFT

The radiation therapy division of the Department of Radiology of the School of Medicine, University of Maryland at Baltimore, has received a gift of $24,392 from the estate of the late Frances M. Meilleur of Washington, D.C.

A cancer victim, Mrs. Meilleur decided to help others afflicted with the disease. In her will she named two friends and her attorney as trustees to determine the best method of carrying out her wish.

After visiting the school's radiation therapy division, they decided to offer the gift to support the division's cancer research and therapy.

Preliminary plans are to use the gift to purchase equipment for the division.

## Lay Hypnotists

A recent story on lay hypnotists in *The Sunday Sun* brought this reply (also published in their columns) from Jacob M. Conn, MD, a professor and lecturer in hypnosis:

"I have been asked to comment on the use of hypnosis by lay hypnotists whose entire training may comprise one three-day course.

"In Maryland the law permits chiropractors and golf pros to practice 'medical' hypnosis. As early as 1958, I wrote that the teaching of hypnosis is part of the framework of psychiatry and psychotherapy, and that a working knowledge of psychodynamics, the study of the patient's conscious and unconscious defenses and his motivations is a prerequisite for the practice of hypnotherapy.

"Whether a doctor becomes a technician or develops into a student of human behavior will depend upon his mastery of the principles of psychodynamics. Any average adolescent can learn to 'hypnotize' after one hour's instruction, but the practitioner who is ignorant of the art of medicine, when and when not to use hypnosis, is barging in where angels fear to tread. Hypnosis may represent a rebirth, reincarnation fantasy, a homosexual relationship; it can symbolize the fear of being dominated, of authority, of the tenor of an intimate interpersonal relationship. It may utilize the hypnotic relationship for deep dependency needs, humiliation, expiation, clarification or guilt. Hypnosis is not a specialty independent of psychiatry and medical psychology. It is an integral part of it."



*Mano Swartz*

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# executive director's newsletter

January 1972

NEW JCAH MEDICAL STAFF BYLAWS

Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations, 1971, for departmentalized hospitals have been published by the Joint Commission on Accreditation of Hospitals.

Copies may be obtained by writing to the Joint Commission, at 645 North Michigan Ave., Chicago, Ill. 60611. Check for $3.25 per copy should be enclosed with the order.

JCAH WORKSHOP SET

A workshop on the newly revised JCAH Standards has been set for February 3 and 4, 1972 at the Hunt Valley Inn.

Reservations for this event must be made in advance by contacting John F. Bacon, Executive Director, Maryland Hospital, Education and Research Foundation, 1301 York Road, Lutherville, Md. 21093, telephone: 821-9500. Registration charge, which includes two luncheons, materials, manuals and workshop, etc., is $50.00.

The workshop is being jointly sponsored by the Faculty and the Maryland Hospital Association.

NEW COMMITTEES NAMED

Two new committees have been named by the Faculty, both of which should have far reaching implications for physicians.

The first is an Ad Hoc group designated to meet with Blue Shield to discuss the many problems involved in payments under Medicare and related programs. Employment of independent legal counsel, knowledgeable in Medicare laws and regulations, has been authorized.

The second is a small, three-man group designated to work jointly with Blue Cross, Blue Shield, and Hospital Association representatives to discuss Medicare details of benefits and related subjects.

NEW COMMITTEES NAMED (cont'd)

Physicians who have any data that would be useful to the committee should send such material to the Faculty office for referral.

BE ON LOOKOUT FOR FIRST ISSUE OF THE ASSEMBLYMAN

The first issue of The Assemblyman, Legislative Newsletter of the Faculty, will be published early in 1972. This will summarize some of the main issues scheduled to come before the General Assembly when it convenes on January 12, 1972.

It will also contain a listing of the proposals being advanced on behalf of the Faculty.

ORCHESTRAL ALLIANCE

An appeal is being made to physicians, wives, and allied professional personnel who are interested in forming an orchestra - strictly for pleasure. If sufficient interest exists, an organizational meeting will be called to discuss it further. Please let us have name and address, in writing, if you are interested.

RESOLUTIONS FOR ANNUAL MEETING

Resolutions for consideration of the House of Delegates at the annual session, May 3, 4, 5, 1972 must be received in the Faculty office prior to Wednesday, March 8, 1972.

PARISIAN TRIP

The Faculty has a trip to Paris scheduled via TWA leaving Baltimore, Sunday, May 14th returning to Baltimore on Sunday, May 21st.

Reservations should be made through:
Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles St., Baltimore, Md. 21201, phone 727-0682.

MAIL SOLICITATION WARNING

Maryland physicians are again being solicited for a $10 "listing" in the U.S. Medical Directory.

This organization has done this on previous occasions. Physicians are warned against the use of such paid listings which are unethical and illegal under Maryland's Medical Practice Act.

John Sargeant

Executive Director

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## STATE DEPT. OF HEALTH AND MENTAL HYGIENE REORGANIZED

A reorganization of the Maryland Department of Health and Mental Hygiene to "improve services to the people of Maryland and to enhance sound business practices," has been announced by Neil Solomon, MD, its secretary.

Centralizing operations into six major offices is a key step designed to bring about clearly established major areas of responsibility that were formerly fragmented and scattered, according to Dr. Solomon.

Heads of the six units will report directly to the secretary and to the deputy secretary, Richard A. Batterton. The six new divisions and their heads are:

1) Office of Program Services-Matthew Tayback, MD, assistant secretary of health and mental hygiene for program services. Associated with Dr. Tayback is Jean Rose Stifler, MD, newly designated deputy assistant secretary of health and mental hygiene. Dr. Stifler previously served as acting commissioner of the State Health Department.

2) Office of General Administration — Herbert H. Rosenbaum, assistant secretary of health and mental hygiene for administration.

3) Office of Legal Services — Paul Walter, assistant attorney general and counsel for the department.

4) Office of Special Services — Henry G. Nathan, formerly director of information services for the department.

5) Office of Community Relations — Phyllis Kirkland, previously coordinator of community relations for the department.

6) Office of Legislative Services — The director has not yet been announced.

Dr. Solomon said the department would be further strengthened by the creation within the Office of Program Services of ten administrations charged with responsibility for actual delivery of health resources. A listing of these ten administrations and their directors follows:

Drug Abuse —
Philip Greene

Mental Health —
George McK. Phillips

Mental Retardation —
Bert W. Schmickel

Juvenile Services —
Robert C. Hilson

Environmental Health —
Howard E. Chaney

Aging and Chronically Ill Services —
Edyth Schoenrich, MD

Preventive Medicine —
Benjamin White, MD

Medical Care Programs —
John W. Morris

Local Health Services —
Jean Rose Stifler, MD

Laboratories and Research —
Robert L. Cavenaugh, MD

## PHYSICIAN'S ASSISTANT GETS AMA DEFINITION

The AMA Board of Trustees and its Council on Health Manpower have recommended the following as a working definition of the term "physician's assistant" or any other term that indicates a new health occupation with qualifications other than those of a licensed physician working in the capacity of an assistant to such a physician:

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

Moreover, there is strong preference within organized medicine for use of the term "physician's assistant" as opposed to "physician's associate," since use of the latter term commonly implies another physician and is therefore confusing.

## SICKLE CELL ANEMIA PROGRAM ESTABLISHED

Under the leadership of Priscilla A. Gilman, MD, the pediatrics department of the School of Medicine of the University of Maryland at Baltimore is establishing a program to attack sickle cell anemia, an incurable disease that affects one out of every 400 Negro children.

A Pediatric Sickle Cell Center was begun this past June when Dr. Gilman, an assistant professor of pediatrics, was awarded a grant for the purpose from the Thomas Wilson Foundation. The center's staff, which will include medical and social work personnel, will supervise the treatment of youngsters with the disease and undertake community education about sickle cell anemia.

The center's staff, with the aid of a special research fund, will work to develop more effective means of controlling or preventing the painful crises. Inpatients and outpatients at both University and Provident hospitals in Baltimore will be included in the center's clinic.

*"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."*

*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

**rehabilitation medicine**

Joint Statement of the

American Congress of Rehabilitation Medicine

and the

American Academy of Physical Medicine and Rehabilitation

# What is Physical Medicine and Rehabilitation?

Physical Medicine is the diagnosis and treatment of diseases by physical means; in its broadest sense, "Applied Medical Biophysics."

Rehabilitation, in this reference, applies to the methods used to restore a disabled patient to his community as the most useful and self-sustaining individual compatible with his residual capabilities.

The physiatrist, who is the specialist in this field, is trained in the broad diagnostic technique known to all physicians. In addition, he is versed in the special diagnostic and therapeutic techniques embodied in his specialty.

What are the physical means used? They include heat, water, electricity, sound, mechanical force, massage, and exercise. Each is used for its special physiologic and therapeutic properties consistent with the medical judgment necessary in each case.

The physiatrist is also concerned in the total rehabilitation process of restoring disabled individuals to their community. His special skills in implementing this, among others, are the aspect of physical rehabilitation in which he utilizes the tools of applied biophysics, ie, Physical Medicine. In addition, he is directly involved in readaptation of the disabled by testing functional capacity, improving residual motor and sensory ability, training in activities of daily living (ADL), and prescription of adaptive devices varying from artificial limbs to orthotic splints for enhancing functions. He recognizes that there are equally important aspects of rehabilitation in the psycho-social and vocational fields. While he is not directly concerned in the methodological implementation, he is involved as coordinator of all these services in pursuit of a common goal for the disabled person. This total involvement stems from training in the specialty as well as from the fact that interest in readaptation to environment brings him to the understanding of the patient's total needs.

The number of patients who need Physical Medicine and Rehabilitation and the multiplicity of disorders require many additional hands to carry out the physician's orders. The professional people most used in rehabilitation are physical and occupational therapists, rehabilitation nurses, and speech therapists. Other commonly required professions contributing patient care are: 1) medical social worker, 2) psychologist, and 3) vocational guidance personnel. Each professional person brings a skill to be afforded the patient who is in need of his service, just as each physician-specialist contributes his skill to the patient's total care.

The patients in need of Physical Medicine and Rehabilitation come from nearly all specialties in the field of medicine. The quality of their care will depend on physiatrists' understanding of the implications of the possible residual disability on future adjustment to life.

# your medical faculty at work

by John Sargeant
Executive Director

The Council met on Thursday, November 19, 1971, and took the following actions:

1. Expressed wishes for a speedy recovery to the Faculty President who has been ill.
2. Adopted minutes of previous Council and Executive Committee sessions.
3. Adopted the financial operating and dedicated fund statements through September 30, 1971.
4. Adopted 1972 Council meeting dates.
5. Extended the appointment of present legal counsel through 1972, with the understanding that fees paid in regard to this appointment would be subject to negotiation when the freeze on professional fees ends.
6. Heard a report on the current status of the professional liability situations in Maryland and approved continuation of the 10-year incidence study on an ongoing basis provided it could be done at a reasonable cost.
7. Agreed to support legislation that would require insurance carriers to report all cases of professional liability wherein an award or judgement is given or wherein a settlement is negotiated.
8. Expressed appreciation to the Committee Chairman, W. Kenneth Mansfield, MD, for his efforts and excellent report made in this regard.
9. Designated the Executive Director as the Faculty's Legislative Agent for the 1972 General Assembly session in Annapolis which opens on January 12.
10. Endorsed the following proposed changes in the Medical Practice Act:

    A change in the law to require physicians to surrender their license to practice medicine and surgery when such is revoked or suspended. There is now no such requirement in the law and a physician can refuse to do so after disciplinary action becomes final, as ordered by the Commission on Medical Discipline.

    A change in the law to permit physicians to delegate duties to any individual including persons certified or licensed to practice any other profession defined by law, in accordance with regulations to be promulgated by the Board.

    A change in the law giving permission to the Board of Medical Examiners to require continuing medical education as a condition to physicians being reregistered.
11. Also voted to oppose any changes in legislation that would extend the area of chiropractic practice as well as continue to oppose any legislation that would require Blue Shield to pay for chiropractic services.
12. Adopted an expression of appreciation to the Legislative Committee Chairman and Executive Director for their efforts on legislative matters.
13. Adopted the following recommendations of the Subcommittee on Immunization Practices:
    Present smallpox immunization law be repealed requiring compulsory vaccination under certain conditions (school children prior to entering school).

    Approve enabling legislation that would provide for a determination to be made by the Department of Health and Mental Hygiene and the Faculty as to what immunizations are required by all health personnel in Maryland.

    If the above items are approved, the Faculty President and the Secretary of Health and Mental Hygiene hold a joint news conference announcing this decision.

14. Adopted the following motion:

    A special committee be designated for the purpose of meeting with Blue Shield to discuss these and related problems so as to clarify them. This group is to have representation of at least one person from each councilor district and is authorized to employ independent legal counsel who is knowledgeable in Medicare laws and regulations.

15. Endorsed the AMA's Medicredit proposal now before the U.S. Congress.

16. Agreed to cooperate in establishing a joint working group along with Blue Shield, Blue Cross, and the Hospital Association to develop appropriate mechanisms to ensure effective Utilization Review in all hospital admissions, length of stay, etc.

17. Adopted the following recommendations of the Peer Review Committee, with the understanding they would be voluntary at this time:

    The Council approve the principle that all physicians participate in a quality control evaluation of laboratory procedures performed in their offices.

    The Council endorse the following programs as acceptable programs meeting the standards for such a quality control:

    P.E.P. (Proficiency Evaluation Program) sponsored jointly by American College of Pathologists, and American Society of Internal Medicine
    Sunderman Program (Philadelphia, Pa.).

18. Referred to the Bylaws Committee a suggestion from the Maryland Podiatry Association that their members be permitted to become Associate Members of the Faculty.

19. Agreed to endorse the following who are being considered for the honors shown:

    Carolyn H. Snyder Pincock, MD, Silver Spring, Md., for appointment to the AMA Committee on Maternal and Child Care; and

    William B. Kouwehhoven, Dr.Ing., Baltimore, Md., for an AMA Scientific Achievement Award.

20. Heard that the Governor has been asked to name a Task Force on the Shortage of Physicians and Allied Medical Personnel; and will seek an audience for the purpose of discussing appointments to this Task Force.

## THE UNCONSCIOUS PATIENT IN THE EMERGENCY DEPARTMENT

A Symposium

**WEDNESDAY, MARCH 22, 1972**

*Sponsored by the Subcommittee on Emergency Medical Services*
*of the Medical and Chirurgical Faculty*
*at the*
*Sinai Hospital, Baltimore*

The treatment of the patient who arrives unconscious in the emergency room will be discussed by several prominent physicians at this all-day symposium.

For the complete program, see the next issue of the Maryland State Medical Journal. A detailed program and reservation form will be mailed to all members of the Faculty and to others upon request.

# Doctors take note...

## Maryland Area Meetings

Feb. 3-4 **Joint Commission on Accreditation of Hospitals.** Hunt Valley Inn, Cockeysville. Sponsors: Md. Hosp. Assoc., Md. Hosp. & Educ. & Research Foundation, & Med-Chi.

Feb. 6 **Maryland Thoracic Society.** 12th Annual Scientific Session. Sheraton-Baltimore Inn. Contact: Md. TB-RD Assoc., 11 E. Mt. Royal Ave., Baltimore, Md. 21202, phone 685-6484.

Feb. 7-8 **12th Annual Scientific Session, Maryland Thoracic Society,** Sheraton-Baltimore Inn. Contact: Md. TB & Respiratory Disease Assoc., 11 E. Mt. Royal Ave., Program. Contact: Dept. of Rehab. Medicine, Sinai Hospital, Belvedere Ave. at Greenspring, Baltimore, Md. 21215.

Feb. 7-8 **Seminar on Perceptual-Motor Dysfunction in Brain-Damaged Adults.** Holiday Inn Downtown, Baltimore. Sponsors: Sinai Hosp. & Md. Regional Med. Program. Contact: Dept. of Rehab. Med., Sinai Hosp., Belvedere Ave. at Greenspring, Baltimore, Md. 21215.

Mar. 1-3 **National Bureau of Standards.** 13th Scintillation & Semiconductor Counter Symposium. Shoreham Hotel, Washington. Sponsors: Nuclear Science Group of the Institute of Electrical & Electronics Engrs., Atomic Energy Comm., & NBS. Contact: NBS Office of Technical Information & Publications, Washington, D.C. 20234, phone 921-2691.

Mar. 18 **Central Maryland Heart Assoc.** Cardiovascular Disease for the Family Physician. South Baltimore Gen. Hosp. Contact: Central Md. Heart Assoc., 415 N. Charles St., Baltimore, Md. 21201.

May 18-21 **Maryland Academy of Family Physicians.** 24th Annual Meeting. Deep Creek Lake, Md. Contact: Daniel Welliver, MD, 19 Ridge Road, Westminster, Md. 21157, or Mrs. Dorothy E. Holman, 10 Gerard Ave., Timonium, Md. 21093.

## American College of Physicians

Jan. 27-29 **Respiratory Function & Therapy, Los Angeles.** Sponsors. ACP, Hosp. of the Good Samaritan Med. Center.

Feb. 1-3 **Understanding & Managing Eczematous Diseases.** Univ. of Oregon Med. School, Portland. Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Feb. 7-9 **Gastroenterology: Digestion & Disorders of Digestion.** Mayo Clinic, Rochester, Minn. Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Feb. 23-25 **Diagnosis & Management of Infectious Diseases.** Univ. of California, Center for Health Sciences, Los Angeles. Contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

### American College of Obstetricians & Gynecologists

Feb. 25-26 **Newer Concepts in Delivery of Obstetrical & Perinatal Care.** Phoenix, Ariz. Contact: Donald J. Zielm, MD, Dept. of Ob&Gyn, Good Samaritan Hosp., P.O. Box 2989, Phoenix, Ariz. 85036.

Mar. 3-4 **12th Congress of the Pan-Pacific Surgical Assoc.** Honolulu. Contact: Cesar B. DeJesus, MD, Pan-Pacific Surg. Assoc., 236 Alexander Young Bldg., Honolulu, Hawaii 96813.

Feb. 28-Mar. 3 **American College of Radiology.** 11th Annual Symposium on Mammography & Disease of the Breast. Nassau, Bahamas. Contact: ACR, 20 N. Wacker Drive, Chicago, Ill. 60606.

### American Academy of Facial Plastic & Reconstructive Surgery

Feb. 6-11 **Rhinoplasty Workshop.** Univ. of Toronto Dept. of Postgraduate Med., Dept. of Otolaryngology, Dept. of Anatomy, Div. of Instructional Media. Sponsor: AAFP&RS. Contact: Mrs. Caroline Flynn, Div. of Postgraduate Medicine, Univ. of Toronto, Toronto, Ontario, Canada.

Feb. 27-Mar. 3 **Workshop in Advanced Rhinoplasty.** Dept. of Otolaryngology, Baylor Univ. College of Med., Houston. Sponsor: AAFP&RS. Contact: William K. Wright, MD, Suite 508 Hermann Professional Bldg., Texas Med. Center, Houston, Texas 77025.

### Miscellaneous Meetings

Feb. 28-Mar. 2 **American Society of Contemporary Medicine & Surgery.** Diplomat Hotel, Hollywood, Fla. Contact: John Bellows, MD, 30 N. Michigan Ave., Chicago, Ill. 60602.

Feb. 28-Mar. 2 **American College of Chest Physicians.** Modern Concepts in Acute & Chronic Cardiorespiratory Care—Newborn & Adult. Steamboat Springs, Colorado. Sponsors: ACCP, Univ. of Colorado Med. Center Pediatric Cardiopulmonary Dept., & Cystic Fibrosis Foundation. Contact: Dept. of Continuing Educ., ACCP, 112 E. Chestnut St., Chicago, Ill. 60611.

Feb. 28-Mar. 3 **Society for Contemporary Ophthalmology.** 1972 Winter Meeting. Diplomat Hotel, Hollywood, Fla. Contact: John G. Bellows, MD, 30 N. Michigan Ave., Chicago, Ill. 60602.

Feb. 28-Mar. 3 **Symposium on Arthritis & Related Disorders.** New York Univ. Postgraduate Med. School, 550 First Ave., New York City. Contact: Office of the Recorder, N.Y. Univ. Postgraduate Med. School, 550 First Ave., New York, N.Y. 10016.

Mar. 1-4 **Medical Practice Legal Course for Doctors.** American Hotel, Bal Harbour, Fla. Sponsor: Univ. of Miami Law Center & School of Medicine. Contact: IV Medical/Legal Institute, Univ. of Miami Law Center, P.O. Box 8087, Coral Gables, Fla. 33124.

Mar. 1-5 **American College of Cardiology.** 1972 Scientific Session. Conrad Hilton Hotel, Chicago. Contact: Wm. D. Nelligan, ACC, 9650 Rockville Pike, Bethesda, Md. 20014.

September 1972 **Maternal & Child Health Program of the Univ. of California School of Public Health at Berkeley.** Postgraduate courses of instruction for pediatricians, obstetricians, & other physicians interested in receiving training in Maternal & Child Health. Programs lead to MPH. Fellowships available. Contact: Helen M. Wallace, MD, School of Public Health, Univ. of California, Berkeley, Calif. 94720.



*Maryland*
**MEDICAL POLITICAL ACTION**
*Committee*

# MMPAC JOINS JOURNAL PAGES

MMPAC serves you! Yes, doctor, if you belong to MMPAC, you have a voice! Consider the alarming increase in the cost of malpractice insurance. The following is a quotation from a speech made in the House of Representatives by the Honorable Gilbert Gude, Republican Congressman from the Eighth District.

"One of the primary topics of concern among our constituents, and one being given an increasing amount of attention in Congress, is the skyrocketing costs of medical care throughout the country. Although we cannot pin down the cause to any one factor, I am confident that the deteriorating situation in malpractice insurance for physicians contributes to the problem.

"As a result of the fantastically high awards given to claimants in malpractice cases, the cost of malpractice insurance has risen precipitously to unacceptable levels — within the past year the cost of some physicians' insurance has gone up nearly 200 percent.

"I receive mail every day, as I am sure you all do too, about the increasing cost of medical care. The prohibitive cost of malpractice insurance for physicians has left them few alternatives other than to pass on their increased costs to their patients. The problem has become a vicious one, and the effect on health care cost is disturbing to providers and recipients of health care alike.

"I want to commend the administration's initiative in dealing with this problem. The President has directed the Secretary of Health, Education, and Welfare to promptly set up a Commission on Medical Malpractice to begin an intensive program of research and analysis in this area. The commission is scheduled to report back with specific recommendations by March 1.

"In addition, I have been meeting with a group of doctors representing the medical profession in my district, and they have voiced great concern about this issue. As a result I have been studying this problem myself, and I am working on legislation for the district, which I am hopeful will be a first step for other areas to follow."

Your MMPAC representatives are foremost among the doctors working with Mr. Gude in trying to solve this problem. Their views will be reflected in the resulting legislation.

President Nixon closed his address at the AMA Convention in June with the following remarks. "I have heard a doctor say on occasion, 'I am only interested in my profession; I am not interested in politics.' Let me tell you something. He had better get interested in politics or he won't have any profession to be interested in."

If you are not already a MMPAC member, contact the chairman in your district. Make your voice a voice that will be heard! Listing follows:

| | |
|---|---|
| First District | William P. Sadler, MD |
| Second District | Howard Moses, MD |
| Fifth District | William Greco, MD |
| Sixth District | Robert Thomas, MD |
| Seventh District | Neil Novin, MD |
| Eighth District | Francis C. Mayle, MD |

Mark these dates on your calendar: March 11-12, 1972, AMA AMPAC WORKSHOP, Washington Hilton Hotel, Washington, D.C. Plan now to attend and learn of PAC work being done over the nation and PAC goals for the coming year. A detailed program will follow at a later date. Consult your district chairman for details.

**DeWITT E. DeLAWTER, MD**
Chairman, Maryland Medical
Political Action Committee

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# Call it what you will, it may be premalignant...

## Before

**3/29/67** Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

**6/12/67** Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



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Nutley, N.J. 07110

# and Efudex® (fluorouracil) 5% cream can resolve it.

## Call it actinic, solar or senile keratoses, many regard it as "precancerous."[1,2]

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,[3,4] offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these mutliple lesions.

## Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.[5] Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.[6]

## Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.[5] The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.[6]

## How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

## Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

**References:** 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer, 25*:450, 1970.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).




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## IMPORTANT INFORMATION

# REVISED RECOMMENDATIONS DECEMBER 1, 1971 FOR DIPHTHERIA, TETANUS, AND PERTUSSIS VACCINE

Routine immunization to prevent diphtheria, tetanus, and pertussis has been widely practiced in the United States for the past 20 years and has resulted in a marked decline in the incidence of these diseases. However, small outbreaks of diphtheria associated with high mortality rates continue to appear in inadequately immunized individuals of all ages. Tetanus, too, is an important health problem. Since the organism is everywhere, there is a need for every person to receive primary immunization and periodic booster doses. Pertussis, on the other hand, is a disease primarily of infancy and is the major indication for immunization with Diphtheria and Tetanus toxoids and Pertussis vaccine (DTP) early in life.

The preparations used for immunization against Diphtheria, Tetanus, and Pertussis are as follows:

1. Diphtheria and Tetanus toxoids and Pertussis vaccine (DTP), used **only** for children under seven years old.
2. Tetanus and Diphtheria toxoids, **adult type** (Td). This is the agent of choice for immunization of individuals seven years and older.
3. Tetanus toxoid (T).

The Steering Committee makes the following recommendations for the immunization against diphtheria, tetanus, and pertussis:

**I. Primary Immunization** (intramuscularly)

A. Children two months through six years of age:

DTP—(Start at two months or as soon thereafter as possible). Three injections at four-to-six-week intervals with a reinforcing dose at about one year after the third dose.

B. Adults and children seven years and older:

Td (adult type)—two injections at four-to-six-week intervals with a reinforcing dose at one year after the second.

**II. Booster Immunization** (intramuscularly)

A. Children younger than seven years:
DTP—one dose given between three and six years of age.

B. Individuals seven years and older:

Td—one dose every ten years (see below for wound management).

ANNUAL BOOSTER INJECTIONS ARE UNWARRANTED (AND SHOULD BE DISCONTINUED). TOO FREQUENT BOOSTER DOSES MAY BE ASSOCIATED WITH AN INCREASED INCIDENCE AND SEVERITY OF REACTIONS.

**III. Tetanus Prophylaxis in Wound Management**

Tetanus prevention is of major importance at the time of wound treatment. An adequate history of tetanus immunization should be obtained, and toxoid should be administered according to the nature of the wound and the patient's history. The following table is a conservative guide to active and passive tetanus immunization at the time of wound cleansing and debridement.

GUIDE TO TETANUS PROPHYLAXIS IN WOUND MANAGEMENT*

| History of Tetanus Immunization (Doses) | Clean, Minor Wounds | | All Other Wounds | |
|---|---|---|---|---|
| | Td | TIG | Td | TIG |
| Uncertain | Yes | No | Yes | Yes |
| 0 — 1 | Yes | No | Yes | Yes |
| 2 | Yes | No | Yes | No[1] |
| 3 or more | No[2] | No | No[3] | No |

1. Unless wound more than 24 hours old.
2. Unless more than 10 years since last dose.
3. Unless more than 5 years since last dose.

Td (Adult)
TIG (Tetanus Immune Globulin - Human)

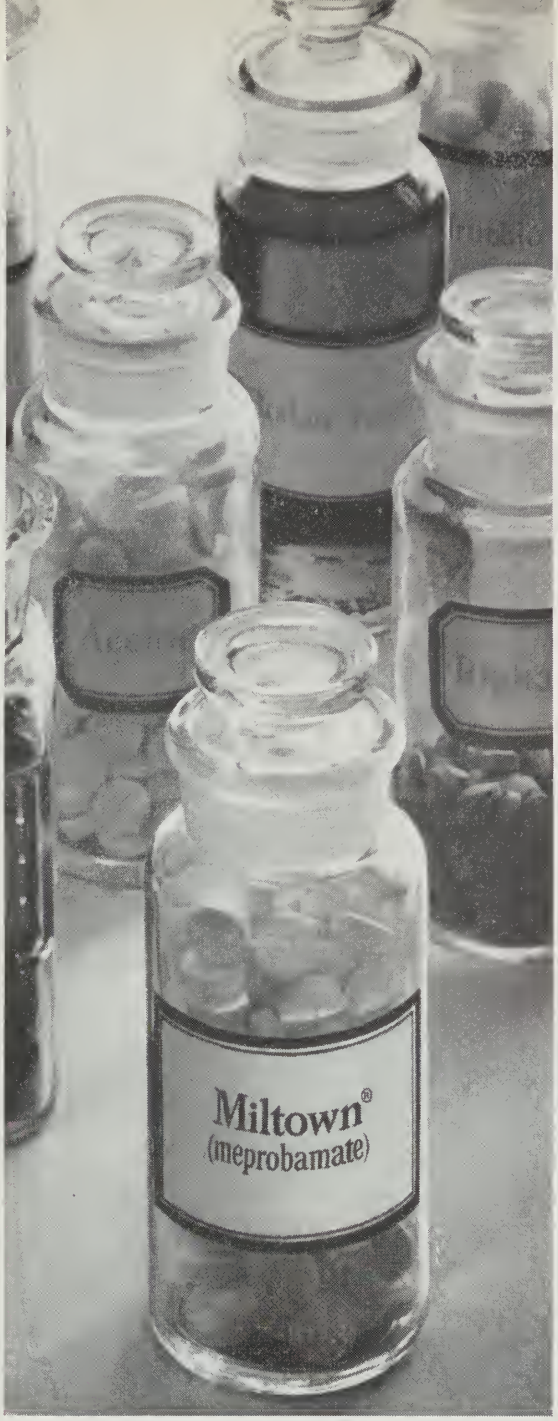
*Morbidity and Mortality Weekly Report, October 30, 1971 Recommendation of the Public Health Service Advisory Committee on Immunization Practices, Diphtheria and Tetanus Toxoids and Pertussis Vaccine.

A. Only if there is reason to suspect hypersensitivity to the diphtheria component should one substitute tetanus toxoid (T) for Td, adult type.

B. Passive immunization for wounds of average severity consists of a dose of 250 to 500 units of Tetanus Immune Globulin (**human**). This is the antitoxin of preference and is far superior to the horse serum antitoxin as it has the advantage of longer protection and freedom from severe allergic reaction. When Tetanus Immune Globulin is unavailable, it may be necessary to use the horse or bovine antitoxin. Before either of these animal sera are used, the patient must be carefully tested for serum sensitivity. At the time the tetanus antitoxin dose is given, an initial dose of Td should be administered at a different site and in a separate syringe. The primary series of Td should then be completed.

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# American Association of Medical Assistants

Norman Kramer, MD, Food and Drug Officer, was guest speaker at the October meeting in the Medical Examiner's office.

Dr. Kramer was born in New York City in 1915. He attended Franklin and Marshall College, Columbia University Graduate School, and the University of Maryland. He holds a PhD degree in Bacteriology. In World War II, he was attached to the Marine Corps as an epidemiologist. He joined the Food and Drug Administration in 1947 as a bacteriologist and in this position served in Washington and Philadelphia. In 1960 he was transferred to Atlanta as a food and drug officer. In this capacity, he was in charge of reviewing district activities, determining violations of the law, and recommending appropriate voluntary legal actions to achieve compliance. He then served in similar positions at Kansas City before being transferred to Baltimore this past March.

His presentation was most informative on the workings of the Food and Drug Administration. Mainly, it is a consumer protection agency to enforce laws in the interest of consumers. The Hazardous Substance Labeling Act and the Toy Safety Act are both results of the research and labors of the Food and Drug Administration. Also, this agency works to do away with medical quackery.

•

On November 2, 1971, elections for the Baltimore Chapter were held. The following officers were elected:

| | |
|---|---|
| President-Elect | Lila Adams |
| Vice-President | Frances Fairley |
| Record. Secretary | Lottie Wolfson |
| Corresp. Secretary | Jean Jacobson |
| Treasurer | Valerie Hachtel |
| State Representative | Rita Cobry |

Installation of the new officers, including the new president, Dorothy Walker, took place on December 10.

Newland Day, MD, was elected to serve a second term as Advisor of the Baltimore Chapter.

•

The Baltimore members also voted to adopt a needy family for Christmas. This project has been in existence since the first year of the chapter's birth and has been one that the entire chapter supports with money, clothes, toys, and household furnishings.

•

The State of Maryland was well represented at the National Convention in Atlanta in November. Members present included: Dorothy Hartel, Frances Fairley, Dorothy Walker, Nell Chaney, Jean Subock, Mary Minnick, and Gertrude Gillum. Also present to support the cause were: Donald Fairley, Bob Walker, George Chaney, Thomas Subock, Mr. Minnick, and Norman Gillum. Maryland was most proud to have such a representation.

•

Mrs. Eleanor Stuck and Mrs. Rita Cobry represented the Medical Assistants at a seminar at the Hunt Valley on Accreditation and Certification in Relation to Allied Health Manpower. All the recommendations from this seminar are to be completed and given to those present within six months.

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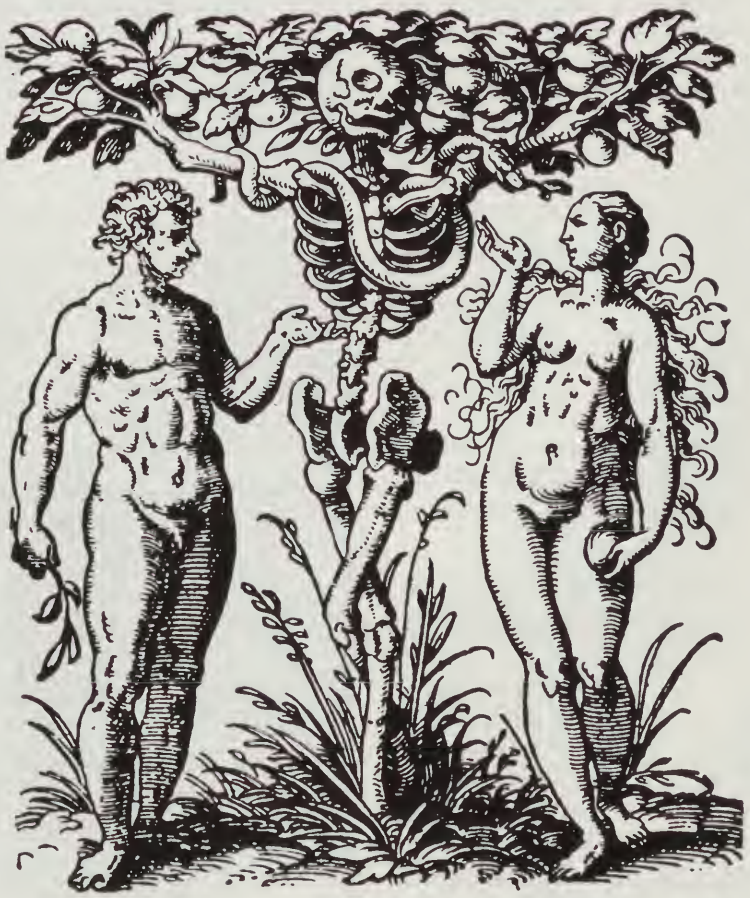
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**Indications:** Acute gonorrheal urethritis and proctitis in the male, and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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**Warnings:** Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

*Safety for use in infants, children and pregnant women has not been established.*

**Precautions:** The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-

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**Active against most strains of Neisseria gonorrhoeae in vitro** (M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included.

JA72 1848-6

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.
*Male*—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
*Female*—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
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**THE CARE OF THE GERIATRIC PATIENT, by E. V. Cowdry, PhD, and Franz U. Steinberg, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

This is the fourth edition of this publication and lists many distinguished contributors. It is divided into several sections: Medical Care, Surgical Care, Nervous and Mental Care, and Delivery of Care.

Because of the intense interest on a national, state, and local level in the improvement of care for the geriatric patient, this book should prove popular. It is most comprehensive in all of the areas it embraces and is a publication that any physician who has the slightest interest or number of patients in this field should want to possess.

**REHABILITATION MEDICINE, third edition, by Howard A. Rusk, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

The author opens the preface to this edition by stating, in part, that ". . . a majority of medical rehabilitation procedures could and should be done by the practitioner or specialist responsible for the patient's primary medical care and that these procedures should be an integral part of such medical care." (1958, 1st edition).

He goes on to stress that this is just as true today, and reserves the treatment of the patient with s e v e r e d i s a b i l i t i e s to the rehabilitation specialist because of the inability of the primary care physician to have at his disposal all the varied facilities, equipment, and skills to do so. It is evident that this book still remains a basic text for physicians who specialize in this field and as a reference work for all physicians. It accomplishes this purpose well and it is a book that all physicians should keep in their medical libraries.

This new edition is in reality an update of the previous two editions, all due to medical advances that take place over any period of time.

**DOCTOR AND PATIENT AND THE LAW, fifth edition, by R. Crawford Morris, LLB, and Alan R. Moritz, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

This book is an all-purpose publication, primarily because it should appeal to physicians, attorneys, and laymen—in particular patients and those who may become patients.

It is a successor to the publication bearing the same name and authored by Louis J. Regan, MD, LLB, who died in 1955. While it is a successor, its content and format have been changed considerably.

With the increasingly high awards being made in professional liability cases, and with the significant increase in the incidence of claims and suits, all physicians would do well to read this. While we know this to be too much to ask of physicians in Maryland, those who have an interest in this field should certainly obtain a copy of it for their own use.

**GENETIC DISORDERS OF THE ENDOCRINE GLANDS, by David L. Rimoin, MD, and R. Neil Schimke, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

This book represents an attempt to catalogue the clinical, genetic, and metabolic features of the known genetic disorders of the endocrine glands. It is anticipated that it will also serve as a reference source for the diagnosis and counseling of families with the well-described syndromes, provide a basis for the recognition of "new" syndromes, and stimulate further investigation into the pathogenesis of the many rare genetic disorders associated with endocrine dysfunction.

The authors state frankly that they may have overlooked some rare disorders and invite readers to call any such omission to their attention.

**SHANDS' HANDBOOK OF ORTHOPEDIC SURGERY, by R. Beverly Raney, Sr., MD; H. Robert Brashear, Jr., MD; with the collaboration of Alfred R. Shands, Jr., MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

This marks the eighth edition of this handbook which incorporates changes in title, authorship, and content.

The presentation of the fundamental facts and principles of orthopedic surgery provides sufficient detail to convey a well-rounded knowledge of the subject.

It is an excellent publication to add to your Orthopedic Surgery library.

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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland



# Children of Alcoholics- A Hidden Tragedy

**WILLEM G. H. BOSMA, MD**
**Director of Alcoholism**
**and Drug Abuse Services and Education**
**University of Maryland Medical School**
**Baltimore**

*This paper was originally presented at the Second Annual Meeting of The American Medical Society on Alcoholism, in conjunction with the Department of Continuing Medical Education, University of Maryland School of Medicine, October 29-30, 1971 at the Thomas B. Turner Auditorium, The Johns Hopkins University, Baltimore.*

The children of alcoholics are the principals in a hidden tragedy. Often they remain pathetically invisible to the professional treating the alcoholic. Worse still, the family tends to be totally ignored in the recent emphasis on rehabilitation of alcoholics; all the efforts and virtually all the literature are aimed exclusively at the alcoholic and his alcoholism. And yet, we know now that more than half of all alcoholics have an alcoholic parent.[1] Furthermore, there seems to be a high incidence of drug abuse and mental disturbance among the children of alcoholic parents. What recognizable problems can we find in the child's early life that can explain this phenomenon?

In treatment, alcoholics' children are seen to have significantly similar behavior and thought patterns. In the home, these children feel unloved and neglected and, as one child said, "My parents make you feel like a burden. They would be better off without you." It is perfectly understandable that the alcoholic in his uncomfortable and guilt-ridden anesthetized state is unable to establish a loving and meaningful relationship with his child. The alcoholic sees the world through a fog that is impenetrable to the emotions of the people surrounding him or trying to reach out to him.

Likewise, in this state, he isolates himself and finds it impossible to reach out or relate to others, even his children. He is self-centered and preoccupied with himself. Nor can the children turn to the spouse for attention and love since the nonalcoholic parent is often too overcome with anger, frustration, and futility to be of any comfort.[2] This parent most often has her own share of inner conflicts. Her inability to recognize the superficial relationship with her spouse and her neurotic compulsion to take care of or "mother" the alcoholic leaves little time for the child.[3] More often than not, she is even unable to provide the child with a caring atmosphere since it is no accident that she has picked an alcoholic spouse. (If it is the mother who is the alcoholic, the situation is even more desperate. Children, especially young children, are more dependent on their mother. Obviously alcoholic mothers cannot care for either their children's physical or emotional needs.)

The alcoholic's children react to this situation

with intense feelings of distrust, rejection, worthlessness, and repressed rage. The inconsistent, erratic behavior of the alcoholic and his spouse makes the child feel insecure. Thus, the home life provides none of the usual sense of security, and no haven to the child from the frustrations of the outside world. In fact, the child is in constant fear of physical violence, because of the aggressive behavior of the alcoholic. He also is a witness to the constant violence between his parents and fears the threats of parental separation he so often hears. The separation may even occur from time to time and increases the child's apprehension and insecurity. "Who will be there when I get home from school? How will they act when I get there? The situation at home is further aggravated because the child emulates the parent in violently taking out his pent-up frustrations on his siblings.

It is obviously difficult for a child to identify in a positive way with an alcoholic parent. Consciously, the child rejects the ugly identification but unconsciously he incorporates the imperfect parent. A confusion is created in the child's behavior because of the conflict between his conscious insight and his unconscious image.

The confusion is manifest in the child's behavior in school and other areas of socialization. School mental health workers frequently find a startling correlation between a child's adjustment problems and his parent's alcoholism. The alcoholic's child is unable to concentrate in school because of anxieties about his home life.[4] He brings many of his aggressions to school with him and is likely to antagonize his teachers and his classmates by his antisocial behavior.

The dulled state of the alcoholic and his erratic, violent behavior isolate him from society and his family. He is unable to relate to or even tolerate other people; instead, he is lost in his own personal world. The isolated behavior of the parent sets a pattern for the child reinforced by the child's shame at his parent's home behavior. Obviously, the child does not want outsiders to know about his home situation. He presents a false front to his peers, lying or phantasizing about his parents. This obviously prevents his forming close friendships. Since such friendships are necessary youthful experience, the child is already caught in the vicious circle that will lead to alcohol, drug abuse, or other maladjustments.

A recent study indicated that male children of alcoholics were assertive, rebellious, and overtly hostile with an overemphasis on masculinity.[5] The daughters, on the other hand, tended to be self-defeating, vulnerable, pessimistic, withdrawn, and fluctuating in their moods.[6] In short, these children have behavior problems. (Although these children are obviously disturbed throughout their development, they are most symptomatic is early adolescence.) They do not do well in school since they find it hard to concentrate. They complain life is no fun. They are often forced to take over the demanding role of a parent—cook the meals, clean the house, put younger children to bed—since a parent is often either missing or emotionally and physically incapacitated. School is no better. Whenever the child is out of the house, he is constantly anxious about how things will be when he returns. He cannot rely on the parents at home and he isolates himself at school because he is ashamed to tell anyone about his anxieties. He fears a humiliating pity from those who might find out. Except for the concern of an occasional individual, doctor, teacher, or minister who looks below the surface behavior, this child can expect little attention or comfort from society.

If the alcoholic parent stops drinking, the


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situation does not seem to improve much. Short-term sobriety generally makes matters worse. The disillusionment of the child is shattering when the parent resumes drinking. All the hopes and dreams of having a so-called "normal" parent are again crushed.

If the alcoholic stays sober, a normal family life does not automatically follow.[4] The individual is often too preoccupied with his recovery to even think about reestablishing relationships with his wife and children. The strained feeling between the spouses often remains. Often the nondrinking spouse feels threatened and insecure at suddenly being confronted with a different and more assertive person. This, together with her understandable anger, may goad him to flee the home. The child is caught in the middle.

Many treatment modalities encourage the alcoholic to attend meetings so that he is spending as much time away from home as he formerly spent drinking. All his social relations have to be relearned, thus causing a further strain on spouse and children, who have already suffered much.

It is clear, for two reasons, that the pathology of the alcoholic's family requires as much attention as the alcoholic himself. One is quite simply that the families — and especially the children — suffer untold anguish which leaves them scarred for the rest of their lives. Secondly, if we are ever going to make a dent in the enormous numbers of alcoholics by practicing preventive medicine, it seems obvious that we must start with the children of alcoholics who, as I mentioned, constitute 52% of all alcoholics.[1]

We certainly should not neglect the agonizing mental problems of the children. It is obvious that the helping professional cannot be satisfied when the alcoholic is diagnosed and treated or sent to AA or a specialized clinic. The family has to be involved; all effort should be extended to make it an adequate unit again, through family and other therapy. (A small number of spouses and children are able to receive help through Al-Anon and Al-Ateen.) Often, if the spouse will not cooperate, treatment should be available to the children. Perhaps the law should even provide that children of alcoholics can be treated against parents' wishes if necessary.

The specialized treatment facilities are not accepting this challenge. It is pathetic that, in a comprehensive alcoholism program such as we have developed in University Hospital, not one clinic, group, or treatment modality concerns itself especially with the treatment of the children of the alcoholic. It is my feeling that we focus our efforts primarily on the alcoholic and fear that paying due attention to the suffering children might harm him by possibly increasing his feelings of guilt and shame.

For the existing alcoholic treatment centers to incorporate the family — and especially the children — into the rehabilitation process, a change of attitude and approach will be required. Above all, it would require expanded treatment facilities and extra personnel. This, of course, is a *sine qua non* in any preventive medicine program. The question is: Do we continue to treat diseases such as alcoholism without making an effort to treat the anguish of the families and, at the same time, prevent future alcoholics or mentally-ill adults?

Are we willing to pay the price now for a future benefit? Our society does not do this very readily.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

# Baltimore City health department

## Dr. Herts—Psychiatric Day Center

John B. Herts, MD, has been promoted to director of the City Health Department's Psychiatric Day Center filling the vacancy created by the retirement of Gertrude M. Gross, MD, in July. Dr. Herts had been Assistant to the Director since July 1, 1970.

A 1966 graduate of Georgetown Medical School, Washington, D. C., Dr. Herts served in a rotating internship at St. Agnes Hospital in Baltimore until 1967. His first year of psychiatric residence was at Spring Grove State Hospital with outpatient experience at St. Joseph's Hospital in Towson. In his second residency year he worked with outpatient adults in the "open clinic" and emergency psychiatry section of the Psychiatric Institute of the University of Maryland School of Medicine and supervised and taught medical students in the Brief Therapy Clinic. His third year of residency included child psychiatry, outpatient adult therapy, and further teaching assignments as well as being consultant to both the Medical Office of the Supreme Bench of Baltimore and to Montrose School in Baltimore County.

The Psychiatric Day Center at 2706 North Charles Street which Dr. Herts now heads was begun in October 1962 under joint auspices with the Maryland State Department of Mental Hygiene to provide psychiatric treatment under medical supervision for the mentally ill adult to prevent 24-hour hospitalization without removing the patient totally from his environment, his family, and friends. To date, the center has provided treatment for 1,293 patients, most of whom have been followed in the center's after-care facility in order to help maintain them in the community.

## Dr. Linas—Maternity Services

Sidney Linas, MD, Baltimore obstetrician, has been named Clinical Director of Maternity Services at the Baltimore Maternity Center, 211 West Lombard Street.

A native Baltimorean, Dr. Linas has been in private practice for over 30 years, chiefly in Baltimore City and Baltimore County. He has been a part-time physician at the Maternity Center for the past three years.

In his new post, Dr. Linas will supervise the operation of the department's maternity hygiene clinics and medical personnel of the family planning clinics. A graduate of The Johns Hopkins School of Medicine, Dr. Linas has also studied at The Johns Hopkins School of Hygiene and Public Health. During World War II, he served in the surgical department of the Army Medical Corps.

The Baltimore Maternity Center provides comprehensive maternity and family planning services for those who cannot afford private medical care. The center is open Monday through Friday from 8:30 AM to 4:30 PM Physicians who may wish to make referrals of needy persons for prenatal and obstetrical services may call 752-0381. For family planning referrals, the telephone number is 752 7282. Director of the Maternity and Infant Services Project 501, which sponsors the Baltimore Maternity Center, is George H. Davis, MD. Both Dr. Linas and Dr. Davis are available for consultation regarding these services.

## Dr. Tommaney—Public Health Resident

Willa Tommaney, MD, will be observing and participating in the work of the City Health Department until March 1, 1972. Her work here is part of a three-year residency in Public Health conducted by the Maryland State Department of Health and Mental Hygiene for physicians working toward board certification.

Dr. Tommaney, a native of Toronto, graduated in 1965 from the Medical School of Queens University of Kingston, Ontario. Following internship, she worked for two years as a Medical Officer of Health with the Bermuda Health Department and the Antiqua Health Department in the British West Indies.

As part of her three-year residency program, Dr. Tommaney obtained the Master of Public Health degree from The Johns Hopkins School of Hygiene and Public Health this year. In addition, she has completed a three-month assignment in epidemiology with the Montgomery County Health Department and six months in the maternal and child health field with the Prince George's County Health Department.

## Proposed Cherry Hill Multi-Purpose Center

The new multi-purpose center to serve residents of South Baltimore is well under way with preliminary plans completed and contracts being prepared and processed by the City Bureau of Purchases. The new $750,000 facility will be located in the vicinity of Giles Road and Veronica Avenue in Cherry Hill on property obtained by transfer from the City Department of Education to the Baltimore City Health Department.

Originating first as a proposal of the City Council Drug Abuse Task Force for a treatment center for drug addicts, the plans were modified to serve the broader needs of the community. In addition to providing office and clinic space for the Baltimore City Health Department, the new building will house service units of the City Department of Social Services, the Maryland State Department of Mental Hygiene, and the State Drug Abuse Administration.

In a new approach, the facility will be constructed on a lease basis from the builder with an option to purchase. Rental will be paid by each of the participating agencies with the City Health Department serving as the agent for the city and as manager of the center.

The Cherry Hill Multi-purpose Center was developed with the close cooperation of the Cherry Hill Coordinating Council and other interested residents of South Baltimore. When completed in 1972 it will serve five communities: Cherry Hill, Mount Wynans, Fairfield, Brooklyn, and Westport. Health Services will be provided by the Southern Health District. The architect is Bernard E. Madison Associates. William Donald Schaefer, Mayor; John B. De Hoff, MD, Deputy Commissioner of Health; James D. Carr, MD, Assistant Commissioner for Local Health Services; Mr. Robert C. Willard, principal planner of the City Department of Planning; and Mr. Shephard Burge, President of the Cherry Hill Coordinating Council, are active in the project.


GET THE FACTS AND BACKGROUND
VISIT THE EXHIBITS

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

MAY 3, 4, 5, 1972

Baltimore Civic Center

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# SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 3, 4, 5, 1972
Baltimore Civic Center

Ample space is available, however, it is suggested that applications be submitted as soon as possible.

## RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

## APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

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5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

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7. Name of institution cooperating in the exhibit: _____

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8. Address of exhibitor: _____

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SEE RULES GOVERNING SCIENTIFIC EXHIBITS



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*1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

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*Overdosage:* The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

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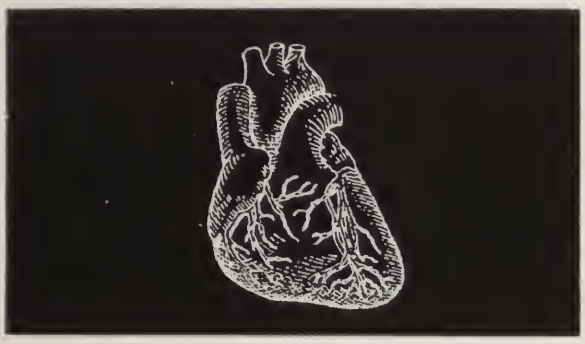
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MORRIS N. KOTLER, MD, EDITOR

*A Service of the Heart Association of Maryland*

**the heart page**

# Electrical Safety and the Heart Patient

**WILLIAM S. STAEWEN, ScB**
**Chief, Division of Electronics and Biological Engineering**
**Sinai Hospital, Inc.**
**Baltimore**

In 1960 an anonymous report appeared in a British medical journal that described a fatal electric shock caused by a cardiac monitor.[1] Later that year Zoll and Linenthal warned that direct electric stimulation of the heart through pacemaker electrodes carried a risk of ventricular fibrillation from technical accidents.[2] They claimed to know of several instances in which transient fibrillation was inadvertently produced by attaching improperly grounded instruments to wires leading to the heart. In 1961 and 1962 several reports were published that described cases of equipment induced ventricular fibrillation in patients with cardiac probes.[3-8]

Recognizing this new threat to the lives of hospitalized patients, Weinberg et al (1962) presented the results of their study designed to determine the minimum current and voltage that, when delivered directly to the heart via intracardiac catheters, would cause fibrillation in dogs.[9] The minimum current they found which produced ventricular fibrillation was 35 microamperes. Whalen et al (1964) and Staewen et al (1969) conducted further studies and documented fibrillatory currents in dogs as low as 20 microamperes.[10,11] These findings were quite surprising and alarming in light of previous studies which indicated that currents as high as 100,000 microamperes were required to induce fibrillation through intact skin.

Equipment was generally accepted as safe if it did not allow currents in excess of 1,000 microamperes (the threshold of perception) to contact a patient. Now the makers and users of electro-medical devices were suddenly presented the difficult task of protecting patients against electrocution from imperceptible currents. Electrical safety in the hospital quickly developed into a national issue. Investigators across the country began to study the situation in their hospitals and reported very grim findings. It soon became evident from the reports of various groups that hospital electrical devices were generally poor in quality, were not properly maintained, were manufactured without adequate standards, were misused and abused, and were operated by personnel who had little — if any — knowledge of the safety hazards involved in using electrical and electronic equipment. The seriousness of the situation was greatly dramatized in 1969 when United States hospitals were accused of accidently electrocuting 1,200 patients annually.[12] There is some disagreement over the validity of this figure, particularly since there is little documentation of actual cases. However, anyone who is knowledgeable about the problem is certain to agree that our hospitals are not a paragon for the safe use of electricity.

There is no doubt that steps must be taken to minimize the risk of electrical accidents in our medical institutions. But the progress up to this point has been, for the most part, disappointing. On the plus side, manufacturers of electrocardiographs and patient monitors have developed circuits for their instruments that limit the current that can flow through patient leads to safe limits. However, the preparation of standards for electromedical apparatus has not been very productive. While the industry is fumbling with self standardization, it is greatly concerned about the prospect of government regulation.

Device legislation as proposed by the FDA has attracted considerable controversy. In addition, some proposals for improving the safety of patient settings, such as the isolation transformer, have caused spirited dialogue between proponents and opponents. This particular issue was temporarily settled in May of 1971 when the National Fire Protection Association (NFPA) voted at its annual meeting not to recommend inclusion of isolation transformers in the National Electrical Code except as previously specified for anesthetizing locations.

The people who have studied this problem do agree on several steps that are necessary to improve the safe utilization of electrical devices in the hospital. They include:

1) well trained operators of electro-medical equipment,
2) dedicated maintenance programs for hospital equipment and electrical distribution systems,
3) optimal grounding of equipment and exposed metal in patient areas,
4) improved quality and reliability of electro-medical equipment, and
5) the establishment of standards and codes that will guarantee safe practices but will not inhibit the development of new techniques.

All of these points are important for effectively reducing the shock hazard. But the most important concept is operator training. It is likely that accidental deaths caused by electrical equipment malfunctions in hospitals are much less common then those caused by operator error. Hospitals have accepted new electro-medical devices in much the same way they procure an improved I.V. drip set or a hypodermic syringe. The medical staff can intuitively handle the I.V. and syringe but very few of them have a background that qualifies them to operate complex electronic equipment. If electrical devices in the hospital are going to be used safely and effectively, better training of operating personnel is essential. Additionally, our health institutions must engage clinical engineering support to facilitate selection, procurement, maintenance, and safe utilization of equipment, and for the training of non-engineering personnel.

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# VIRAL UPPER RESPIRATORY DISEASES

HOWARD J. GARBER, MD
T. A. DADISMAN, JR., MD
Division of Communicable Diseases
Preventive Medicine Administration
Department of Health and Mental Hygiene
State of Maryland

This is the time of year when physicians are seeing an increased number of patients with upper respiratory infections. The clinical syndromes now prevalent are caused most commonly by viruses; however, bacteria, rickettsia, and mycoplasma also play minor etiologic roles.

In general, the upper respiratory illnesses which result from virus infections are acute, self-limited, and occur in epidemic form. The type of clinical disease expressed is usually influenced by the age and health of the person, his previous experience with the specific virus and subsequent immunity developed, and the site of viral invasion of the respiratory tract. Of major public health concern is the significant work and school absenteeism which results from acute respiratory infections. Over one third of all workdays lost and about two thirds of all school days lost for medical reasons are attributed by some studies to respiratory illness.

The spectrum of disease may extend from the common cold to a more serious febrile illness with superimposed bacterial complications. One symptom complex currently prevalent includes coryza associated with acute nasopharyngitis, cough, sinusitis, earache, and general malaise lasting from five to seven days. Fever is rare. The white blood cell count is usually normal. In adults, this illness, known as the "common cold," is most often caused by rhinoviruses, of which there are probably over 100 distinct serotypes. Similar symptoms may be associated with parainfluenza viruses, adenoviruses, and respiratory syncytical viruses. In children, viruses other than rhinovirus are most often responsible for this syndrome.

Acute pharyngitis with exudates in children and infants may be caused by adenovirus (1, 2, 5 and 6). However, parainfluenza (1 and 3) and several members of the Coxsackie A group can also cause this illness, which is self-limited, accompanied by slight fever and some cervical adenopathy. It must be differentiated by throat culture from streptococcal pharyngitis which usually has a more sudden onset. Adenovirus Type 3 is associated with a conjunctivitis as well as an acute pharyngitis.

Herpangina and acute lymphonodular pharyngitis caused by the Coxsackie A virus group is characterized in the former by small, rapidly-ulcerating vesicles and in the latter by erythematous nodules located on the anterior pillars and soft palate. The illness which usually occurs in children is characterized by fever, mildly sore throat, headache, and general malaise, with a short course of from three to five days. The season of greatest incidence is summer and autumn.

The presence of laryngitis and acute tracheobronchitis is associated with parainfluenza viruses, respiratory syncytical viruses, rhinoviruses, and influenza viruses. The predominant symptoms of tracheobronchitis are productive or nonproductive cough, fever, pain on swallowing, and occasional substernal discomfort. Laryngitis may

be associated with a dry cough, pain on swallowing, and hoarseness. Bacterial infections with *Hemophilus influenzae* and *Corynebacterium diphtheriae* must be differentiated by laboratory examination from these less severe nonbacterial syndromes.

Acute bronchiolitis is most often caused by respiratory syncytical virus. This illness, which occurs in infants and young children, resembles bronchial asthma except that the child is febrile and may have signs of pneumonia. There may be a two-to-three-year periodicity of epidemics of this clinical entity.

Involvement of the lung with a bronchopneumonia may be associated with influenza virus, adenoviruses, parainfluenza viruses, and respiratory syncytical viruses. Lobar consolidation is rarely caused by viruses. Viral pneumonias predominate in children and young adults, whereas bacterial pneumonias occur in individuals with underlying disease or in the older age group. *Mycoplasma pneumoniae,* a microorganism intermediate between a virus and bacterium, causes an illness, most often in young adults, and usually subclinical. The only finding may be a pulmonary infiltrate noted on X-ray. Clinically, bronchitis and pharyngitis may be present, with the predominant respiratory symptom being cough. Malaise, fever, headache, myalgias, and sore throat may also occur. This category of illness may be differentiated from bacterial involvement of the lungs by sputum smear, culture, and by serological tests.

This short review of syndromes primarily of the upper respiratory tract should give some help to the practicing physician. It is realized that most often diagnosis must be made clinically without benefit of laboratory results. Therefore, knowing what is prevalent in a community can offer some guides to diagnosis and therapy.


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# Baltimore County Medical Assn.

## OCTOBER MINUTES

The October meeting of the Baltimore County Medical Association was held at the Good Samaritan Hospital on Wednesday, October 20. After a delicious lunch, provided by the hospital, the meeting was called to order by the president, John Krager, MD. Dr. Krager thanked the staff of the hospital for our invitation and introduced and welcomed these new members, all MDs: John Randall, Louis Olsen, Humberto Certeza, and Erwin Bacmeister. Dr. Patterson introduced Mr. Richard Botson, a first-year medical student at the University of Maryland, Dr. Patterson's preceptee during the school year.

**Program:** Dr. Levickas announced the next meeting will be at St. Joseph Hospital on November 20 and the December meeting will be at the Tail of The Fox.

**Board of Governors:** Dr. Gallager gave a report of the board meetings on August 11 and September 8. A letter was received from the Regional Planning Council with a questionnaire concerning some additions to the Franklin Square Hospital. In the future, the Regional Planning Council will ask the Association to comment on any extension plans for any hospital in Baltimore County. Dr. Krager read a list of the Peer Review Committee members for approval, and the Board approved his appointments. A letter was received from the Doctors' Team in Bowie, Maryland who wish to participate in our emergency house call system. The Board moved that we not endorse the proposal of the Doctors' Team at the present time, and it was felt that the Medical and Chirurgical Faculty look into the legality of the proposal. It was duly moved, seconded, and carried that the report of the Board of Governors be accepted.

**New Business:** The election of the members of the Nominating Committee was held. Inasmuch as there were six nominations, a written ballot was held. The doctor members nominated were: Margaret Sherrard, S. J. Venable, Jr., and J. D. Drinkard. Dr. Krager appointed, as additional members, E. Gordon Grau, MD, and Wilmer Gallager, Jr. MD. Dr. Gallager was appointed chairman of the committee. The members of the Peer Review Committee are: Clarence MC Williams, MD, Chairman; John De Carlo, MD, Radiology; Robert Yim, MD, Pediatrics; B. B. Velez, MD, General Surgery; Alfred Iwantsch, MD, Ophthalmology; D. McClelland Dixon, MD, Obstetrics; J. Nelson McKay, MD, Family Practice; Raymond Bahr, MD, Internal Medicine; and E. Gordon Grau, MD, Psychiatry.

There being no further business, the meeting was adjourned.

Following the meeting, Dr. Levickas introduced Gordon Walker, MD, who brought greetings on behalf of John Collins Harvey, MD, and introduced the speakers. The speakers acquainted our members with the Pulmonary Division, the Arthritis Division, the Rehabilitation Program, and the Renal Program at the hospital. Following the scientific session, tours of the hospital were conducted.

Alfred E. Iwantsch, MD
Chairman, Public Relations Committee

## NOVEMBER MINUTES

Members of the Baltimore County Medical Association met at St. Joseph Hospital on Saturday, November 20. Following a delicious lunch, provided by the hospital, the business meeting was called to order by the president, John Krager, MD. Dr. Krager thanked the administrator of the hospital and the staff for inviting us to hold our meeting at the hospital. He welcomed the new members: Carl Ebeling, MD, and Gary Ehrlich, MD.

**Program Committee:** Dr. Levickas stated that the final meeting of the year would be held at the Tail of the Fox in Timonium on December 16.

**Hospital Committee:** Dr. Holcomb, Chairman, announced the meeting of the Hospital Committee was held on November 2. This Association was requested to make comments on the merits of construction at the Franklin Square Hospital and the St. Joseph Hospital. Franklin Square Hospital will construct a Nuclear Medicine Department and St. Joseph will construct a Psychiatric Unit and an Intensive Care Unit. The committee recommended that these be approved and the committee submitted this to the Association for their approval. It was moved, seconded, and carried that we write to the regional planning council that these projects be approved.

**Nominating Committee:** The following slate of officers was submitted by the committee:

President .....Herbert Levickas, MD

Vice-President ..... B. B. Velez, MD
Secretary ..... J. D. Drinkard, MD
Treasurer ..... Eugene Riley, MD

| Delegates | Alternates |
|---|---|
| William Andersen, MD | William Wade, MD |
| D. D. Caples, MD | Raymond Bahr, MD |
| Melvin B. Davis, MD | Roger Windsor, MD |
| E. Gordon Grau, MD | Louis Pratt, MD |
| Alfred E. Iwantsch, MD | John Hyle, MD |
| William Roemmich, MD | Edward Kreig, MD |
| Samuel Sgalia, MD | Theodore Toulan, MD |
| Margaret Sherrard, MD | Frank Kasik, Jr., MD |
| S. J. Venable, Jr., MD | Theodore Patterson, MD |

Nominee for the State Nominating Committee: Charles O'Donnell, MD.

State Policy and Planning Committee: Donald Roop, MD.

Motion: Dr. Grau moved that the nominations be closed. The motion was seconded and carried.

**Applications for Membership:** On proper motion, the following applications were approved: Harry P. Anastopulos, MD; John Crossan O'Donovan, MD; Carl Jean Posner, MD; Irvin H. Cohen, MD; Ferd Kadan, MD; Arguro Norico, MD, active membership; and George A. Bedon, MD, associate membership.

There being no further business, the meeting was adjourned.

Following the meeting a very interesting scientific meeting was held. The speakers and their subjects were:

"Current Trends in Children's Surgery" — John N. White, MD, Associate Professor of Surgery, Johns Hopkins Hospital;

"Care of the Ostomy Patient" — Marvin M. Schuster, MD, Chief of Gastroenterology, Baltimore City Hospitals; and

"Cardiac Conduction Defects" — J. O'Neal Humphries, MD, Associate Professor of Medicine, Johns Hopkins Hospital.

Alfred E. Iwantsch, MD
Chairman, Public Relations Committee


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PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

**library**

# How Does Your Library Stack Up?

Instead of the follow-up from the regional meeting in Winston-Salem promised in last month's page, a discussion of the two attractive brochures published by the Medical Library Association seems more timely.

The first, directed toward administration, titled *YOUR MEDICAL LIBRARY . . . DEBIT OR CREDIT?* rates hospital libraries by three vital factors, namely: librarian, collection, and facilities.

Taking these categories in order, some of the questions asked are:

1. Has your librarian?
   - A clear understanding of the hospital's objectives?
   - Recognition as part of the hospital team — in terms of authority, responsibility, and salary?
   - Communication channels with you, the administrator, and other departments?
   - An advisory committee representative of the library's users?
   - Formal training in library science, particularly health sciences?
   - An interest in and financial backing to participate in local and national meetings?
2. Is the library's collection?
   - Open to clinical staff as well as physicians?
   - Supported by an annual budget that takes into account current prices, today's literature explosion, and service costs?
   - Strengthened by serials that supply up-to-date information backed up with a five-year supply of most-used journals?
   - Well stocked with books of the last five years?
   - Supplemented by active interlibrary loan program?
   - Cataloged and classified?
   - Rich in new reference books such as indexes, dictionaries, directories, and handbooks?
3. Do your library facilities provide?
   - A central location on a traveled route?
   - Quiet quarters with temperature and humidity controls?
   - Enough room for growth? For staff? For storage of materials?
   - Photocopying?
   - Furnishings conducive to browsing and study?
   - Trained assistants available to readers?
   - Suitable hours?
   - Loan privileges?
   - Consistent simple arrangement of books and journals?

These are a few of the criteria for judging a good hospital library — or any other type health sciences library. Copies of this flyer may be secured by writing to: Executive Secretary, The Medical Library Association, Inc., 919 N. Michigan Ave., Chicago, Ill. 60611.

The second brochure titled simply *MEDICAL LIBRARY ASSOCIATION,* 1971-72, explains briefly the functions of the MLA, giving current officers, objectives, membership information, benefits, a list of publications, and a short history. Copies of this also are available from MLA.

We have welcomed Mr. Joseph Jensen, formerly of the University of Colorado Medical Center, Denver, Colorado, who joined our staff in November as Assistant Librarian.

## NEW ACCESSIONS - BOOKS

**(arranged by subjects)**

CANCER

**The Year book of cancer, 1971.** Chicago, Year Book Medical Publishers. QZ 200 Y4 1971.

CARDIOVASCULAR SYSTEM

Bang, Nils Ulrik

**Thrombosis and bleeding disorders; theory and methods.** New York, Academic Press. WG 610 B3 1971.

CHILD PSYCHIATRY

**Annual progress in child psychiatry and child development, 1971.** New York, Brunner-Mazel. WS 1 A6 1971.

DIABETES

American Diabetes Association, Inc.

**Diabetes Mellitus: diagnosis and treatment.** American Diabetes Association, RC 660 A5 v.3 1971.

DRUG ADDICTION

Medical & Chirurgical Faculty of the State of Maryland. Subcommittee on Narcotic Prescribing Habits of Physicians.

**Report. Ethical guidelines for physicians in the treatment of narcotic addiction.** WM 270 M4 1971.

GENETICS

Lynch, Henry T

**International directory of genetic services.** 3d ed. New York, National Foundation — March of Dimes. Ref. QH 431 L9 1971.

HOSPITAL LEGISLATION

Maryland. Laws, statutes, etc.

**43GO1-Standards and regulations for acute general hospitals and special hospitals.** Baltimore, Md. State Dept. of Health. WX 32 AM3 M2 1959.

IMPAIRMENT EVALUATION

American Medical Association. Committee on Rating of Mental and Physical Impairment.

**Guides to the evaluation of permanent impairment.** Chicago, AMA. W 925 A5 1971.

MEDICAL LIBRARIES

Medical Library Association. Committee on Surveys and Statistics.

**Health Science Libraries of National, State, and Local Medical Organizations.** Ref. Z 675 .M4 M4 1967.

PLANNED PARENTHOOD

**Advances in planned parenthood, v.6.** New York, Excerpta Medica. International Congress Series. HQ 763 A2 1971.

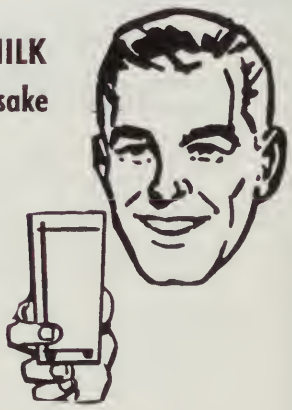
PSYCHOTHERAPY

**Current psychiatric therapies, v.11.** New York, Grune & Stratton. WM 5 C8 1971.

SURGERY

**Surgery annual, v.3.** New York, Appleton-Century-Crofts. WO 100 S8 1971.


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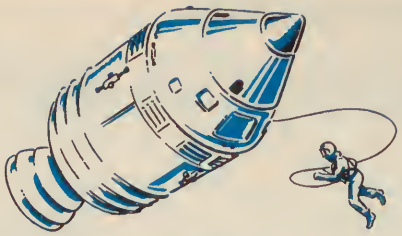
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# Alexander Hamilton

**DOUGLAS CARROLL, MD**
**Baltimore City Hospitals**
**Baltimore**

*"I still retain a little of my native honesty, not having quite lost myself in the American subtilly and selfishness . . . . . The longer I live I discover more rogues and fools and see more into my own folly and imprudence"*

*Alexander Hamilton's Letterbook*

*This is the third of a ten-part series of articles on the history of medicine in Maryland written by Dr. Carroll. The first appeared in February, the second in September, and others will be published on an intermittent basis.*

Alexander Hamilton (1712-1756) is best known in Maryland history as the founder of the Annapolis Tuesday Club, a lively social club made up of the intellectuals of Annapolis. It was started by Hamilton in 1745 and did not meet after his death in 1756.

He was born in Scotland in 1712, one of nine children of Dr. William Hamilton, Professor of Divinity, and Principal of the University of Edinburgh. He received the finest education available, including the coveted Doctor of Medicine from Edinburgh. He spent some time at Leyden, where he may have met Dr. Hermann Boerhaave.

Hamilton's thesis was *De Morbis Ossium*. He came to Maryland in 1739 to join the Reverend John Hamilton, his older brother. That he was immediately successful in the practice of medicine is explained by the fact that he was of excellent family, well educated, proficient in his profession, a young bachelor, and a gay and attractive person.

His letterbook[1] consists of a series of letters from a newly arrived physician to his family and friends in Scotland, giving his first impressions of Annapolis. There is a good deal of information on the medicinal plants of Maryland and Virginia, a special scientific interest of the time.

A letter written June 13, 1739 notes that his medical practice took him "out 10 or 12 miles . . . to see some patients." Some of the local discomforts and accidents of the times are described: "we are pestered here with vermin of various kinds, such as muscettoes, buggs and ticks, which sticking in the skin, pleague on sufficiently and sometimes fester."

"It sometimes rains and freezes here at the same time, so that the trees in the woods are sometimes broke with the Iceicles upon them, severall people here are what they call frost-bit, and lose their limbs by gangrenes occasioned by the frost . . ."

"I being then (September when he received last letter) in a very low state with fevers and a bloody spitting. I am now considerably better, but am following up with an incessant cough, which no medicine whatsoever can abate or diminish, this makes me apprehensive that the consequences will be a confirmed consumption, tho I believe there is yet no such distemper formed, yet I run a great risque."

In a letter of November 6, 1743, he says: "I am not well in health, and for that reason Chiefly Continue still a Batcheller, I have more fatigue and trouble than I care for . . ." Again in a later letter he refers to his health: "I am sure that these warmer Suns have much impaired my

health, for I have suffered much from the excessive heat of this climate, very harassed every summer with a discharge of blood from my lungs . . . but I always recruit again in the winter . . ."

His friend and classmate, Dr. Adam Thomson of Philadelphia, considered him doomed and so reported in Philadelphia, so that when Hamilton met Dr. Cadwalader in that city on his journey on June 13, 1744, the latter asked Hamilton "if Hamilton of Annapolis was dead or alive." To which Hamilton replied: "Here he is, bodily and not spiritually." He improved somewhat and made preparations to return to Scotland in September. He continued to improve, feeling well enough to run for the City Council of Annapolis. By the winter of 1743 he was considering a trip north for his health and recreation.

In his Itinerarium[2-3] he tells about his trip.

### The Itinerarium

Dr. Alexander Hamilton's *Itinerarium* has a curious history. It is an account of a journey from Annapolis to Boston and back in May to September 1744. It was written with no thought of publication "as a slight token of his love and respect" for his good friend Signor Onorio Rozolini, an Italian friend who was visiting in Annapolis. The manuscript remained in Signor Rozolini's family until around 1900, when it was sold to William K. Bixby of St. Louis. During the interim it was completely unknown. In 1907, it was privately printed in an edition of 487 copies with an introduction by Albert Bushnell Hart, Professor of History at Harvard University. This edition[2] is elaborately illustrated with reproductions of the original manuscript, is leather bound, and has a special may and excellent index. In 1948, a new edition,[3] prepared from the original manuscript, was published by the Institute of Early American History and Culture under the direction of Mr. Carl Bridenbaugh in a popular edition.

In many ways Alexander Hamilton fulfilled the ideal of the Renaissance man. Born into the aristocracy of family and learning, he was poet, wit, bon vivant, and a well-rounded man of letters. He lived in Annapolis, which Jonathan Boucher deemed "the genteelest town in North America." New England was largely cut off from these Renaissance influences because of its academic preoccupation with saints and religion.

It happened to be written at a point in colonial history when the medieval class structure was beginning to break down, and the common man was expressing his liberation. Secularization and new wealth were in the ascendency. Alexander Hamilton, a product of European culture, was particularly sensitive to the growing independence of the lower classes, expressed in their rough manners and personal questions. Coming from the colony of Maryland where the class amenities were still observed to some degree, Hamilton was struck by the rudeness, pushiness, and boorishness, not only of the lower classes, but of the pretenders to gentility. There was a strong unconscious class structure; the new emerging element was the realization by the middle class that it could aspire to the upper class.

### Hamilton's Sensitivity

Hamilton is particularly sensitive to and irritated by ignorance. He repeatedly castigates both the high and low for ignorance. Of the ferryman Terrence at Elk Ferry, he notes "he let me know that he understood some scraps of Latin." A clergyman joins him at Brandywine, and Hamilton notes he was "not overlearned." Inquisitiveness irritates Hamilton even more. He repeatedly states that people are "inquisitive as to where I came from," "ignorantly inquisitive," "a man of inquisitive disposition." He notes that the people of Philadelphia are inquisitive concerning strangers. As he enters Trenton, New Jersey, he is greeted with "staring and gasping." Perhaps Hamilton's laced hat and sword had something to do with his reception. In several places he notes the new custom of handshaking, apparently foreign to Edinburgh and Annapolis.

Even more irritating to him was affectation and pretentiousness. He meets a number of men desiring "to pass as a gentleman." An acquaintance "pretended to have been familiar with great folks."

His consciousness of social class extends to his Negro slave Dromo who, meeting a Negro woman in Long Island who spoke only Dutch, was unable to make out what she was saying and solved the problem by: "You damn black bitch" and so rode on.

He confuses the religious sects which he encountered. The Quakers he refers to as "that obstinate generation, the Quakers." He meets Jews, Moravians, and Methodists, all of whom he condemns with equal vigor.

His own reading consists largely of the best authors of the day. He finds a copy of Fielding's *Joseph Andrews* which he reads with zest.

It should not be concluded that Hamilton was a dour, humorless Scotsman. He casts fun at

himself, admitting freely his succumbing to the charms of a young woman of the lower class on the York ferry.

Hamilton was, however, quite class-conscious, looking with little compassion or understanding on those he met. Perhaps his rigid European views make him a better observer of the early colonial scene because he had standards of another culture by which to judge the new civilization.

Hamilton knew personally very few people outside of Annapolis. He carried introductory letters to prominent citizens of each community he intended to visit. There was already a self-conscious aristocracy of education and leadership. Most of the letters seem to have been to the leading physician in each city along the coast, and since many of them were of European origin and education, it is natural that they might be known to one another. This is particularly true of the Edinburgh graduates, many of whom came to the large cities in the colonies.

From the medical point of view, the journal reveals a good deal about the medical practice in the colonies. It is interesting to note the omissions. In the *Itinerarium,* there are few references to medical diseases and patients. Medical matters were rarely discussed with physicians he met on the trip. There were no hospitals to visit and the medical practice was largely carried on by private physicians in their offices and in the patients' homes. Most sick people were cared for at home. He gives a good description of the types of medical practitioners. Hamilton himself was at the very top of his profession. This group consisted of those educated at European schools — Edinburgh and Leyden were preeminent. The physicians he met in various large towns were the leaders of the medical profession. It is interesting that they entertained him at the local tavern and spent much time drinking and playing backgammon. Few asked him to their homes unless he was staying for a prolonged period in the city. A number of the physicians he met were also clergymen. He looks down on the empiricists, and calls all who learned from preceptorship alone "barbers."

In Joppa he meets a miller "and another greasy-thumbed fellow, who, as I understood, professed physick, and particularly surgery in the drawing of teeth."

"He practiced upon the housemaid, a dirty piece of lumber, who made such screaming and squaling as made me imagine there was murder going forwards in the house. However, the artist got the tooth out at last, with a great clumbsy pair of blacksmith's forceps."

He describes another physician at Huntington, Long Island, who had been a shoemaker in the town but happened to cure an old woman several years before and had become a physician.

"The doctors in Albany are mostly Dutch, all empyricks, having no knowledge or learning but what they have acquired by bare experience. They study chiefly the virtues of herbs, and the woods there furnish their shops with all the pharmacy they use. A great many of them take care of a family for the value of a Dutch dollar a year, which make the practice of physick a mean thing and unworthy of the application of a gentleman. The doctors here are all barbers."

Dr. Hamilton considered that he had learned all there was about medicine during his training period. There is very little evidence that any of the physicians he met, even in the large cities, made much effort to improve their medical knowledge through reading or other means. Dr. Hamilton mentions that he had seen Heister's book of surgery recommended in the "Physical News" from Edinburg, but there is no other reference to a medical magazine.

In discussing a pet monkey and the monkey's owner, Hamilton notes the continuity of species: "The progress of Nature is surprising in many such instances. She seems by one connected gradation to pass from one species of creatures to another, without any visible gap, interval or discontinuum in her works."

On September 25, Hamilton crossed on the Susquehanna Ferry. The people standing at their doors along the roads looked like so many staring ghosts "in short I was sensible I had got into Maryland, every house was an infirmary, according to ancient custom."

In later life he married Daniel Dulany's daughter, thus linking himself to one of the great legal minds of the time, and a darling of the proprietor.

It was as a member of the Tuesday Club, however, that Hamilton was at his best. Writing many years later, Upton Scott, the first President of the Medical and Chirurgical Faculty of Maryland, noted that Dr. Hamilton "was a man of strict honor and integrity, of a friendly benevolent disposition and a most cheerful facetious companion amongst his friends, whom he never failed to delight with the effusions of his wit, humor and drollery, in which acquirements he had no equal. He founded the Tuesday Club, of which he might be considered the life and soul, as it expired with him, having never assembled after his death."[3]

# Dr. Alexander Hamilton's Defence of Dr. Thomson's Discourse on the preparation of the body for the Smallpox

Smallpox inoculation consisted of transplanting pus from the pustule of a smallpox victim into a puncture in the skin of a healthy person. Some physicians in England had heard of the practice by 1700, but it was Lady Mary Montague, wife of the English Ambassador to Turkey, who experimented on her own children in 1718 and 1721, got the support of the Royal Family, and publicized the procedure.

Zabdiel Boylston first used it in America on his and Cotton Mather's children during a serious smallpox epidemic in Boston in 1721. There was an outcry against its use at first, but it gradually gained in popularity and acceptance. In Southern Maryland, inoculation was being practiced by Richard Brooke and Adam Thomson in the 1740s. In 1747 the Legislature did not meet at Annapolis because of rumors of smallpox.[4] There were also small outbreaks in Maryland in 1743, 1755, 1756, 1760, 1762, 1765, 1767, and 1771.[5] In 1757 the Legislature met in Baltimore because the smallpox "continued to rage in Annapolis."[4]

Scotch physicians made up the majority of European physicians who migrated to the colonies after 1730.[6] Among these were Dr. Adam Thomson in about 1738 and Alexander Hamilton, a close friend and classmate at Edinburgh in 1739. Hamilton had a brother at Annapolis and settled there. Thomson practiced in Prince George's County where, with Richard Brooke, he became one of the well known smallpox inoculators.[7] Having built a reputation in Maryland, Dr. Thomson decided to move to Philadelphia in about 1748. He aroused immediate resentment on arrival in Philadelphia by advertising in the newspapers that he would practice physic but would not keep a public apothecary shop. Most physicians did keep apothecary shops and made a fat profit from selling drugs. Not so Dr. Adam Thomson. The local physicians felt that he looked down on them as tradesmen, as indeed he did.

On November 21, 1750 he presented a "Discourse on the Preparation of the Body for the Small-pox and the Manner of receiving the Infection"[8] before the Trustees of the Philadelphia Academy. Medical lectures before lay audiences were frowned on by the local physicians. The address was erudite and specific. Looked at today, it is obviously the product of a powerful intellect, befitting a graduate of University of Edinburgh. From his position as a graduate of a leading European university, Thomson was at no pains to hide his contempt for the empirical practitioners and quacks whom he found around him. "Innoculation has been shown to be much the best and safest way of taking the infection, yet even in this way it sometimes proves mortal; and indeed, considering how uncautiously and precipitantly this is often done, I am surprised it has not been much more frequently the case. Innoculations seems to be considered by many as a mere chirurgical Operation, accordingly we see almost everyone who knows how to handle a Lancet intrusted with the whole Management of it; But it has been shown, that what ought to be done on this Occasion for the Safety and Security of the Patient, a judicious and skilful Physician only can judge. In Matters of Property and Interest prudent Men are always cautious and circumspect, in proportion to the Value of the Thing in Danger. Now here, Life itself, the most valuable of all earthly Things, is liable to be put in the most imminent Danger by Mismanagement and want of Skill; and yet of all Professions in America the true Qualifications of a Physician are the least examined into. This seems something strange and inconsistant, but Fact is notorious. It may, perhaps be occasioned in some Measure, by a Notion which prevails even among some from whom better things might be expected, that Physic is not a *real Science,* founded on just and rational Principles, but a Sort of *Knack* to be got entirely by Practice, which an ignorant, illiterate Person, may as readily attain, as one of Learning and Knowledge, who was taken due Pains to study it."

Thomson continues in this vein, recommending licensure for an improvement in medical practice.

The discourse was followed by an outcry against Thomson on the part of the local physicians. The attack was led by the dean of Philadelphia's practictioners, Dr. John Kearsley, a many-sided virtuoso, expert architect, assemblyman, an amateur astronomer, and the first man to use inoculation in Philadelphia. Kearsley was naturally contentious. In *A Letter to a Friend*[9] he charged Adam Thomson with ignorance of the medical authorities where "Rules of Practice in a Science" cannot "be prostituted to the Vain Chimeras of a doubtful Hypothesis." Kearsley's pamphlet was relatively mild. He takes Thomson to task for claiming knowledge which he did not have. He accuses

Thomson unjustly of claiming that there were specific drugs for the treatment of smallpox. Kearsley particularly attacks the use of antimony, mercury, and the bark, although Thomson had specifically warned against dependence on these drugs.

Kearsley's pamphlet is perhaps most valuable historically because of a long digression on yellow fever as it appeared in Philadelphia in July and August 1747. Here Kearsley describes the symptoms seen and treatment used in these two early epidemics.

When Thomson's pamphlet was published by B. Franklin and D. Hall in 1750, Thomson affixed a preface in which he defended his ideas. He notes that he had not attacked the true practitioners of the science or any other duly qualified physician. He reiterates his statement that "Physick is a Science founded on just and rational Principles, and that the Knowledge of these Principles are absolutely necessary to qualify a Man for being a safe, practical physician."

With Olympian dignity, he submits his case to posterity: "If the discourse has any merit it will find friends; if not, it will be neglected and forgotten."

The attack on Dr. Thomson brought at least one supporter to his side. The fact that a fellow physician in another city was willing to write and publish a pamphlet of 27 pages reveals the emotional involvement and strong feelings of the European-educated physicians against what they considered the poorly educated local practitioner.

To be sure, Dr. Aexander Hamilton of Annapolis was a fellow student of Thomson. His defense of Dr. Thomson took the form of a pamphlet directed to a physician in Philadelphia.[10] Hamilton carries the attack on quacks farther and makes a personal attack on the revered Dr. Kearsley of Philadelphia. He points out that he is a fellow student in physic and an intimate acquaintance of Thomson. The charge of vanity Hamilton defends by noting that a man who tries to serve the public cannot be vain and vicious. There is no crime in communicating knowledge to the public by means of the press. He goes on to attack Thomson's adversaries by showing that their criticisms are brought on through malice and envy.

Thomson's *Discourse* is then m i n u t e l y examined and no parts are found to be without support from previous literature. This literature is examined extensively.

On the charge that Thomson has given offense to the profession, Hamilton adopts a much bolder and less temperate manner. He makes the point that university degrees do not necessarily make good physicians: "But are there not a Set of forward Prigs, who every where set up for physicians, and trifle with Men's Constitutions, without the least Grain of those necessary Qualifications of Learning and Common Sense? Have we not heard of, and seen, Fools of forty Years old, who have become Physicians, and never studied Physic or been capable to study that or any other Science? Have we not many Stage-Doctors, who travel about to cure (as they impudently assert) incurable Distempers? Are there not Seventh Sons, who have an inherent Virtue of Curing, and who are born Doctors? Are there not many Juggling Fellows, who pretend to tell all Distempers by Urine? Have there not been Porters, Cobblers and such like Gentry of compleat Education, who have made Estates by their Elixirs, Balsams of Life, Grand Specific Tinctures, Pills and Electuaries, and such like Impositions and Fooleries? — In fine; Are there not many that Class themselves among the regular Practitioners of the healing Art, whose whole Education has been in the Shop of some half-learned Apothecary; where their chief Study has been to con over the Labels of the Drawers, Vials and Gally Pots, and to compound a Recipe *secundum Artem*?"

Hamilton then goes on to use the invective so common in the political pamphlets of the day against the enemies of Dr. Thomson. He notes that Thomson has defended Dr. Mead's criticism of Boerhaave: "I must own, indeed that this learned Gentleman (Dr. Thomson) acted very cautiously, to jump in with so acurate a Writer as Dr. Mead. But, I think, his Assurance was not small, to thrust himself with so little Ceremony into such good company and calls to my Mind a certain Fable, of some Apples and Horse Turd, washed by an inundation from a Farmer's Yard, floating down the River in Company.

A Ball of new-dropt Horse's Dung,
Mingling with Apples in the throng;
Said to the Pippin, plump and prim,
See Brother, how We Apples swim!

Swift"

Hamilton continues the attack on Dr. Kearsley accusing him of misquoting passages from Thomson's *Discourse* and writing so poorly and in such a long-winded way that his meaning is not clear. He notes a misquotation in Kearsley's *Letter to a Friend*: "I can scarce believe Mr. Kearsley did it on purpose; but rather am apt charitably to think, as I am informed the Gentleman is advanced in Years, that his Eye-Sights fails him, and he cannot plainly dis-

tinguish between Commas, Semicolons, Colons and Points:"

Thus with a very heavy hand, Hamilton defends his classmate and attacks with sarcasm and scatological references his adversaries. In addition he make a personal attack on Dr. Kearsley, drawing attention to his age and poor eyesight.

To today's reader, Hamilton's defense is crude and sarcastic, an unnecessary tract in very poor taste.

In the end Thomson won out. Kearsley apologized for the attack. Thomson introduced the use of mercury and antimony to Philadelphia. He was also the first to have public lectures on medical topics.

Thomson's *Discourse,* its reception by Philadelphia physicians, and Hamilton's *Defence* reveal much about eighteenth century medical practice in the American Colonies at mid-century. Medical "knowledge" was dogma gleaned from medical authorities of the past. Experience was a source of knowledge only to the well educated (preferably European educated) physician. That is, medicine was a science, taking long and arduous study. From this it followed that licensure was a necessity to protect the public. Neither Hamilton nor Thomson took pains to conceal his contempt for those trained by practice only.

The subject of the *Discourse* is typical of colonial medicine in that it deals with an epidemic disease. For smallpox, yellow fever, and intermittent fevers were the serious diseases of the eighteenth century in the colonies.

Vaccination against smallpox was introduced into Baltimore in the summer of 1800 by Dr. John Crawford. There was a good deal of resistance to the use of vaccination despite Dr. James Smith's demonstration within a year that vaccination protected against the natural disease. Finally approved by the medical faculty in 1802 and 1805, it is of great interest that two physicians, Dr. James Anderson and Dr. J. K. Rogers, used inoculation until 1814 and 1816 respectively. Inoculation was forbidden by law in Maryland in 1850.[5,7]

Inoculation with smallpox was first tested on a statistical basis by Cotton Mather during the severe Boston epidemic of 1721. He reported that one in six who took the natural disease died, whereas of 300 inoculated, only one in 60 died. The fear of the disease terrorized the eighteenth century. Physicians became known as skillful inoculators. Of these, Adam Thomson was the best known, and his "American Method" became widely accepted throughout the colonies. Accurate figures on the prevalence and fatalities from smallpox were not kept until 1811,[5] but we know there were at least nine epidemics between 1743 and 1771 with the Legislative forced to call off its meeting in 1747 and 1757. Other well-known inoculators in Maryland were Richard Brooke, Henry Stevenson, Gustavus Richard Brown, and Samuel Thompson.[7]

John Adams' experience with the "American Method" of inoculation is given in his letters to his fiancee Abigail Smith in April 1764.

"A long and total Abstinence from every Thing in Nature that has any Taste, Two heavy Vomits, one heavy Cathartick, four and twenty Mercurial and Antimonial Pills, and Three Weeks close Confinement to an House, are, according to my Estimation of Things, no small matters — However, who would not chearfully submit to them rather than pass his whole life in continual Fears, in subjection, under Bondage." Later Dr. Nathaniel Perkins "divided the skin for about a quarter of an inch and just suffering the blood to appear, buried thread about a quarter of an inch long in the channel — a little lint was then laid over the scratch and a piece of rag pressed on, and than a bandage bound over all."[11-12]

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# The Late Apical Systolic Murmur*

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**During the last five years evidence has accumulated that an apical systolic murmur confined to the latter part of systole, unrelated to coronary artery disease, is not necessarily benign or functional in nature. The late systolic murmur was initially related to extracardiac structures, such as the pericardium. Since these late systolic murmurs were frequently associated with mid systolic clicks and since pericardial adhesions were seen at autopsy in some of the latter patients, the belief in a benign extracardiac origin was a natural assumption. However, a number of observers have recently presented evidence that the late systolic apical murmur and even the mid systolic clicks may 1) arise from the mitral valve and its supporting structures, 2) be associated with a characteristic deformity of the mitral valve, 3) be associated with mild to moderate late mitral regurgitation and 4) not necessarily be benign in clinical course.**

### Clinical Characteristics

Patients with late apical systolic murmurs and late mitral regurgitation have generally been young or middle-aged adults with a predominance, in our experience, of females between 20-40 years of age. Occasionally, a history of rheumatic fever is elicited, but generally no definite etiologic factor can be ascertained for the murmur. Oftentimes, the murmur was first noted in childhood and this, plus the occurrence in more than one family member, suggests a congenital and familial incidence in some patients. Most patients are asymptomatic, and were referred for study only because a murmur was present on routine examination. Some may have palpitations, easy fatigability, and breathlessness on heavy exertion. Most functionally are class I or II (N.Y. Heart Assoc. Classification).

### Apex Phonocardiography

No significant vibrations are present in early systole. The murmurs occupy the last one half or two thirds of systole and tend to be crescendo in character ending with the aortic closure sound. The murmur may be initiated by one or more systolic clicking sounds. Mostly, the murmurs would be graded 2-3/6 and there is little radiation of the sound from the apex. The late systolic murmur responds to drugs in a fashion similar to the typical holosystolic murmur of mitral regurgitation. With phenylephrine, which raises blood pressure and LV pressure, there is an intensification of the holo- and late-systolic murmurs of mitral insufficiency. When amyl nitrite is inhaled and the systemic arterial pressure decreases, these murmurs decrease in intensity.

### Electrocardiograms

In general, the electrocardiogram is normal although occasionally the criteria for left ventricular hypertrophy may be present. Some cardiologists have described significant electrocardiographic changes in association with late systolic clicks and murmurs. These generally consisted of abnormal T-waves and S-T segments in leads 2, 3, and AVF. In addition, ventricular extrasystoles and paroxysmal tachycardia were seen.

### Chest Roentgenography

Generally, no significant abnormalities are detected by roentgenography. In a few patients, however, definite but mild left ventricular and left atrial enlargement are apparent.

### Cardiovascular Hemodynamics

In most instances, intracardiac pressures and

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the cardiac index are normal. Rarely, mild elevation of left ventricular end-diastolic pressure and left atrial A-wave is found.

### Angiography

Cineangiography in the right or left anterior oblique projections demonstrates the characteristic mitral valve deformity. During early systole the leaflets of the mitral valve balloon or prolapse backward into the left atrium as contrast material passes from the left ventricle into the aorta. Then, only during the latter part of the systole does the contrast material regurgitate from the left ventricle to the left atrium. The degree of mitral regurgitation is usually only mild to moderate and the left heart chambers are normal in size. A few patients have been seen, however, with more severe "late" mitral regurgitation with definite left atrial and left ventricular enlargement.

Simultaneous electrocardiograms, external and internal phonocardiograms, and pressure tracings have been compared with the cineangiographic data. There has been a fair correlation between the beginning of the late systolic murmur and the first appearance of the contrast material in the left atrium. The systolic click coincided with the timing of the maximum prolapsing of the mitral valve leaflets into the left atrium.

### Clinical Course

In those patients with a late systolic murmur, mild mitral regurgitation, normal electrocardiogram and normal chest X-ray, initial studies have shown a relatively uncomplicated clinical course.

Since this type of murmur is heard so frequently in any diagnostic cardiac clinic, we believe that the lesion is generally benign. It is certainly possible that some of these patients may progress to the development of a holosystolic murmur and acquire the hemodynamic as well as clinical characteristics of the more common forms of mitral valve insufficiency. Some of the patients with holosystolic murmurs may have begun their clinical course in this way and were not followed up closely because of the initially benign course, and hence, the transition may have been missed. Only by recognizing and following closely the patient with the late systolic murmur, will the ultimate prognosis be known.

It must be appreciated, however, that some of these patients may develop bacterial endocarditis following dental procedures. Therefore, the usual precautions against bacterial endocarditis should be instituted whenever a patient with this type of murmur is seen. We have, in addition, seen two patients with late systolic murmurs who had 3+/4 mitral regurgitation cineangiographically and definite mild left ventricular and left atrial enlargement. If their clinical course follows that of other forms of mitral valve disease, surgery may be necessary at some future time.

A group of patients has been described with late systolic murmurs and midsystolic clicks, abnormal T-waves, prolonged Q-T intervals, prominent U-waves and a high incidence of extrasystoles and paroxysmal tachycardia. A familial incidence was noted and also the occurrence of psychiatric disorders. One patient had seizures related to atrial flutter with 1:1 conduction and sudden death occurred in one patient.

Therefore, although the course in these patients is usually benign, the physician must guard against the development of bacterial endocarditis and be prepared to control the arrhythmia that may appear in those with abnormal resting electrocardiograms.

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# Treatment of the Alcoholic and the Family

## A panel-symposium sponsored by the Committee on Medicine and Religion of the Medical and Chirurgical Faculty


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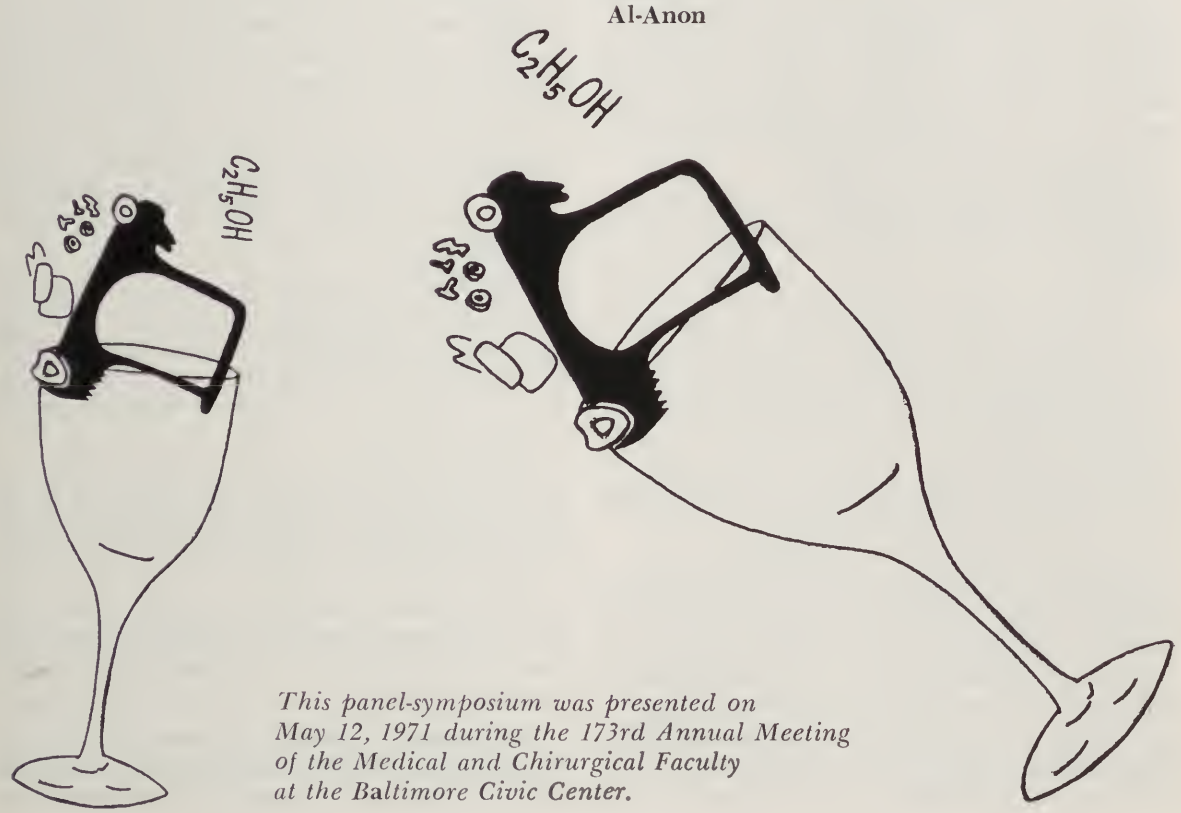
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**MRS. S**
Al-Anon


*This panel-symposium was presented on May 12, 1971 during the 173rd Annual Meeting of the Medical and Chirurgical Faculty at the Baltimore Civic Center.*

*Dr. Singewald*: This panel-symposium was mainly designed for clergymen and lay people who often are the first to see alcoholics. The medical profession often sees this problem at a later stage. In talking to members of the clergy, we asked them what was the one medical problem that they seemed to want help with most, and alcoholism was first on the list. So this is one of the reasons that we have directed this panel to clergymen.

Alcoholism is a drug problem that is creating more havoc, pain, economic loss, and death than any other. It is the third most common illness in this country. It is estimated that there are nine million alcoholics and another nine million people with some drinking problem. When you add their families, the problem becomes enormous.

Advances have been made in two directions in recent years: one, in medical management and two, in community resources for management. These advances will be explored by the panel.

We are directing our efforts to supplying physicians and clergymen with information that may be helpful to the patient and the family, those who so often first see the alcoholics.

To open the discussion, let us say that a parishioner has come to see a clergyman who lives in West Baltimore. She is talking to him about her husband who, she says, has been drinking for several months but for the last week has been drinking heavily and has remained drunk for a week. He has become very sick. He has been vomiting a good bit. And she comes to the minister and says, "What shall I do? What can I do to help this man?"

The minister at that point picks up the telephone and knows enough to call Reverend Shelley and says, "What do I do with this man?"

*Reverend Shelley*: Now of course the answer to this question will depend on many things. If the man is very sick, perhaps he is going to go through withdrawal from alcoholism. There are certain hospitals in our city which do admit patients as alcoholics. Provident was the very first hospital in Baltimore City to set aside five beds for detoxification of alcoholics.

So first I would find out something about the person, and try to decide whether he needed to be in a general hospital or not. I'm not a physician. However, as Coordinator of Alcoholism Programs I'm fortunate enough to be in a facility where there are medical people. I would consult them and find out the possibility of getting the person into a detoxification unit if that was so indicated.



It may be that the person doesn't need detoxification. Perhaps he's not going through withdrawal, and may need some help through counseling or AA. We have an alcoholism center in Baltimore and if a person is able to come to the center I would by all means try to make an appointment for the person to see one of our workers. Or, as the case may be, I have very good friends in AA. I wouldn't hesitate at all to call some of my AA friends up to look in on this matter and see what they could do to help out.

It would depend on the case itself. But we are fortunate in Baltimore to have some hospitals, and we have physicians who will admit patients as alcoholics.

*Dr. Singewald*: Let's say that he was too sick to be seen as an outpatient and you had to get an ambulance and take him to the hospital. And let's say you took him to the nearest hospital in West Baltimore — University Hospital. What would you do next?

*Reverend Shelley*: If they took him to University Hospital, he'd be in the good hands of Dr. Bosma and I wouldn't have much to do except say a prayer for him.

*Dr. Singewald*: Dr. Bosma, what would happen if he presented them into the emergency room at the University Hospital by ambulance, fairly acutely ill?

*Dr. Bosma*: Well, University Hospital's philosophy is that there should be many options for the patient who comes in for treatment. In

the emergency room we have counselors who are available 24 hours a day. They evaluate the alcoholic together with the physicians that are on call and decide where the patient will go.

Now, if he has a medical problem, for example, and we feel that included in the medical problem is the withdrawal from alcohol which may lead to all sorts of problems like rum fits and DTs, and also perhaps the patient is in very bad physical shape, then he would be referred to the surgical or medical wards. (As you know, alcoholics seem to have 30% of all the diseases for which people have to be hospitalized in in this country.)

In the past several months, some alcoholic patients, because of their poor condition, were admitted to the shock-trauma unit. They may be referred to the psychiatric wards in the Psychiatric Institute. They may be referred to the Quarterway House, the Tuerk House. This is a house for alcoholics who are able to stay outside the hospital but are not ready to go home and are too sick to go home and can stay for about two weeks.

Of course, if the patient is not very ill, he can be referred to the outpatient clinic which meets on Monday for after-care. He can be referred to about six group clinics that we have at University Hospital. He can be referred for personal counseling, either by a psychiatrist or an alcoholism counselor. As a last resort he can be referred to one of the state hospitals. The patient is referred to a state hospital depending on where he lives in Baltimore. But the majority of the patients that we see are served by University Hospital and given the services that we have developed there.

*Dr. Singewald*: Dr. Smoot, suppose this man was in your hospital. After the emergency care had been rendered and he was admitted, are there any specialized services that he might receive while he was there that would be different than the average patient receives in the hospital?

*Dr. Smoot*: The patients who are admitted to the alcoholic unit at Provident Hospital also have the services of an alcoholic counselor. And the alcoholic counselor not only serves as the admitting officer but also as the social worker.

He or she contacts the family and tries to get as much information and background on the individual's problem.

Many of our aides or nursing assistants are former alcoholics, so they make the patient feel a little more at home and can gather quite a bit of information from them.

We also have a very close affiliation with AA and the AA members come in and visit these patients at regular intervals. And when the patient is discharged from the unit, he is usually referred to the alcoholism clinic as well as to AA meetings and the AA members who are following these individuals take them there and see that they are shown the way.

This is just the initial step, the first part being the detoxification. The length of stay in the unit has averaged about six days.

*Dr. Singewald*: The Quarterway Houses were mentioned just a while ago. Suppose this patient had to go to a so-called Quarterway House. Would you tell us how this is arranged and what would happen at the Quarterway House?

*Dr. Smoot*: We have just recently acquired a Quarterway House. Now the individual can be discharged from the unit to the Quarterway House and there they have counselors too, and in fact our counselor has some nursing training, so that these patients still may be watched up to approximately two weeks in the Quarterway House.

One other thing that I think has been very good about the Quarterway House: there are a number of alcoholics who can really be detoxified outside of the hospital. These are the ones who may come into the emergency room and after being examined by the physician there it is felt that they could do satisfactorily in a Quarterway House and can be sent directly to the Quarterway House, treated up to a two-week period, and then either discharged home or maybe sent to a Halfway House.

*Dr. Singewald*: Reverend Young, suppose that this minister referred this patient to Reverend Shelly — how should he participate in the care of this patient? Should he just drop the whole thing and let the physicians take care of the patient or should he follow up and possibly keep some contact with this family?

*Reverend Young*: This question is often asked by the minister when he makes the referral.

In my opinion, he shouldn't drop him at all. I think he's still the pastor of that patient or person, and I personally believe very much in the healing team idea, working together.

I also think that the whole family is sick — not just the alcoholic but the whole family gets sick in this deal — and he can be most helpful in encouraging and maybe educating and helping the family to understand this problem.

*Dr. Singewald*: At this point, are there any questions from the audience?

*Question*: What's the difference between a Quarterway House and a Halfway House?

*Reverend Shelley*: A Halfway House traditionally is the kind of dry little island between treatment and community, where the person to be admitted is sober. He's now going back into the community to work or to seek new employment or training.

The Quarterway House, for want of a better term, is an extension of the emergency room, where the person is still sick.

Now in Baltimore we have three such facilities: one with The Johns Hopkins Hospital located at the Flynn Home at 1846 North Gay Street; one at the University Hospital named after Dr. Isadore Tuerk, Tuerk House at 106 North Greene Street; and one at Provident Hospital which is called the Provident House at 1611 Baker Street, the old rectory of St. Gregory's Church.

*Dr. Singewald*: And the Halfway Houses, are they at the same locations?

*Reverend Shelley*: Halfway Houses are located throughout the city both for men and women. I have been associated with Valley House for some 14 or 15 years. This is under the auspices of the Episcopal Diocese of Maryland. It is not run by it but we have been supported by it.

Halfway Houses are all over the city. There are about 16 for men and one for women.

*Dr. Singewald*: This particular patient we're talking about is now ready to leave the Halfway House and either go back home or go to work, and someone wants to refer him to AA. Now how do we go about that?

*Mr. Don H.* (*A member of AA*): You mean that the wife of the man has been advised to call AA?

*Dr. Singewald*: That's right.

*Mr. Don H* (*A member of AA*): You mean That's the Intergroup Office.

Probably the first question that would be asked would be this: will your husband consent to talk with us? Now, that's important. Unless he will consent to talk to us at that point in time it perhaps is useless.

Perhaps the person on the end of that line will ask this question — I haven't heard it asked yet — is he in real bad shape, and have you called your family doctor?

This becomes more and more important if there's a relationship there. In any event, the caller will be given an understanding of what alcoholism is and that this is a sick person. Every encouragement will be given to help him arrive at a decision, not binding, where he will consent to talk to somebody who will come out to see him.

It will be explained in the language of a recovered alcoholic, and sometimes the patient doesn't want any part of it.

More frequently, some time during the coming-out period as he shakes off the hangover he'll say, "All right, I'll talk with them." And there's where we want to be and we will be there if given that opportunity.

Now we're speaking here in generalities and that's difficult. Each case is separate.

Two things I like to know on these calls: one, how sick is he as nearly as the woman can tell and, has she called the family doctor?

In my many years of sobriety, where a family physician has been present and where AA has been there, it has been my personal experience no one has ever been refused help. I was never refused. The family physician is a pretty important person in my opinion.

*Dr. Singewald*: Then if he agrees to talk with you and expresses a desire to get some help, do you arrange for him to go to some chapter near his home, or how do you go about this?

*Mr. Don H*: We'll help in a lot of ways. The only requirement to get into AA is a desire to stop drinking. And perhaps we can go beyond that. A fellow asked me one night, "Are you having a little trouble with the booze?" And that was all it took. There was something in his voice that said this guy knows.

So we take it from there. But if he needs medication or medical help, we're not physicians. The family physician takes over. That being absent, these resources that have been discussed here, these detoxification centers, are wonderful. They save a lot of people from dying. And they're just coming into the picture. We'll help on that, each of us in his own way. We cart them around to the hospitals. We do what we can.

Now, there are about 160 AA meetings in the Baltimore area each week. We have some in the morning, we have some in the afternoon for the night-shift boys; there are numerous meetings available. We'll get them to a meeting, we'll get them started, we'll get them a sponsor. The primary reason for that is our very lives depend on doing that.

*Dr. Singewald*: The family — the wife and children and the family — are often involved in this difficult problem, and we have heard of this organization called Al-Anon. A good many people may not know about it.

Mrs. S, would you tell us a little bit about Al-Anon and how this fits into the picture.

*Mrs. S* (*A member of Al-Anon*): Yes, we start

with the same steps and the 12 traditions that the AA people start with. They are working to stop the drinking. We find out we have to work on ourselves. If there is one person in a family that's sick and it's an illness like alcoholism, the rest of the family is bound to be ill. You can find them crying, whining, or whatever. They are usually considered even more ill than the alcoholic in their own way. They're a mess. I was.

If you call for an AA person for yourself, if this AA person is conversant in Al-Anon, he will either call or bring an Al-Anon member with him. For me the man came to the house, picked up my phone, dialed a number, and said, "Speak to her."

I hadn't talked to my neighbors in six months, so this was kind of a difficult thing to do until she said something about Al-Anon. I didn't know what it was. An hour and a half later I hung up the phone.



This is a family treatment. You are talking to people who have been there. Maybe some of the women or the men who try to help you will be living with the problem right now. They understand. They will listen. They will help. They will help by being there. My phone is on the nightstand. Sometimes I get calls at odd times in the night simply for someone who needs someone to listen to, to get some of the garbage out so they can start thinking again.

This is considered a mental problem by an amateur, in that the person has to start thinking again. We bluntly tell them to get off the alcoholic's back. It's an honest program. Leave him alone. Shut your mouth. And work on your own program. They say it's a selfish program because usually for years you've helped this poor alcoholic out, and then you've helped this damned alcoholic out and, you know, you're being a beautiful martyr at doing without yourself; so they're saying, think about yourself for a change. Let the AA people work with him and you get with the Al-Anon.

The children of the family are also affected. I had four adorable little children who sat on a couch when I went visiting. This isn't normal for three boys and a girl, not at all. They were very quiet, very obedient. Well, I went to Al-Anon and they got a little bit better; now they're pretty noisy. And this is great. As I got better, I transmitted this to my children. It works out marvelously. I'm very grateful to have found this. I got pushed into it.

It's a program of attraction, however. You cannot force a person to join unless he or she is ready, and I was willing for anything because it got pretty rough.

*Dr. Klinefelter*: I use or try to use Al-Anon a great deal because one of the big problems with alcoholism is motivating the person to stop drinking, and it's one disease that many people don't realize they have when they have it. So I suggest to the relatives that they call Al-Anon.

What happens when they call Al-Anon?

*Mrs. S*: There's a Baltimore answering service; there's a Frederick answering service; there's one in Annapolis. They are not usable maybe 24 hours a day because two of them are in private homes. But if you call and you say "I'd like to find out about Al-Anon" or simply, "I need help," they'll take your name, your address, your phone number. They will look through their list. Our Baltimore answering service has about 50 or 60 meetings listed in their area and they are located on a map. If they can get you located on a map, they will contact someone from the groups that are nearest you and have them call you or you call them.

They will send you literature from the Baltimore answering service. They will now send you a Maryland directory and you can go to a meeting wherever you want to in the State of Maryland. There are now 70 meetings.

*Question*: Do these meetings occur regularly, the same way that the AA meetings occur?

*Mrs. S*: Yes, they do. And most of the time they are in the same place as AA. They're a joint venture.

*Question*: Do the spouses know that their wives or husbands are going to Al-Anon?

*Mrs. S*: Well, this is an individual thing.

*Question*: What do you recommend?

*Mrs. S*: You kind of have to suit yourself. In my case it was fine with my husband because he thought that I was some kind of a nut. And then he dropped away and he didn't make it. I wanted to go. It was my very life. And as I got a

little bit bitter and didn't react when he pushed the buttons, he got mad and didn't want me to go. So there were a few battles. Because by then I was committed.

*Question*: I think it's true that none of the Al-Anon members have an alcohol problem. They're living with an alcohol problem, but they don't have the problem themselves.

*Mrs. S*: Not necessarily. If you have two alcoholics married, you have the need for Al-Anon.

*Question*: Well, which one goes?

*Mrs. S*: Either one, or both. The only requirement for going to Al-Anon is that you have an interest in someone, whether friend or family. That's all.

*Dr. Singewald*: Let's give the telephone numbers again, if you'd like to write them down.

The AA telephone number, daytime, is 467-4667; at night, 467-6133; Al-Anon, 823-1222; and BACA, that we're going to hear about in a minute from Dr. Beacham, 366-5555.

These are terribly important telephone numbers to have. And the AA telephone number is the very first number in the telephone book.

Dr. Klinefelter, would you say something about the alcoholic who comes to your private office and is not going to be hospitalized. Is there any drug therapy that you might use that could help him in his decision to stop drinking?

*Dr. Klinefelter*: I think the first thing that is important is for physicians to realize and believe that this is a disease, not a disgrace. This is the thing that you have so much trouble convincing the patient about.

But I've learned that if you have a high index of suspicion and you're aware of the fact that this is the third most common disease, many times you will be able to make the diagnosis without going into the patient's home. And one of the questions that I have found most helpful when I've looked at the person and talked to him for awhile and get to that part of the history, instead of asking him how much he drinks, ask the simple question, "What do you do about alcohol?" And many times the floodgates come down and they tell you all the things they do about alcohol, which just reinforces your feeling that they probably do really have a problem.

Now to get back to the question Dr. Singewald asked — what medicines are available. The things that are available that should not be used are sedatives, because alcohol is a disease of sedatives. Alcohol is a sedative, and it's another form of sedativism. So you don't give alcoholics pills to calm their nerves.

I find that the majority I see have to come to the hospital or go to some other place than where they've been in order to stop drinking. But after you've once gotten them to stop, either by placing them in a hospital or a Halfway House or a drying-out unit, you have them go "cold turkey." Incidentally, most Baltimore hospitals now will admit patients with the diagnosis of alcoholism. Anyway, you don't wean them away from alcohol, you stop it right away. And you give the patient whatever medicine they need to tide them over that period of four or five days before they can settle down.

Then there is a drug that is very helpful in getting the alcoholic not to drink until he's able to understand what you're talking about. And some very good work has been done at City Hospitals to show that alcoholics who have been drinking heavily for some months just don't understand what you're talking about for two or or three weeks after they get off the stuff. They have an acute brain syndrome, and it takes that long for them to realize that they have a disease, and to understand what you're trying to tell them.

The drug I'm talking about is *Antabuse,* and it's a drug that does deter drinking because if a person takes *Antabuse* and drinks he gets terribly sick. If he doesn't drink it doesn't affect him.



I use this a great deal in the early stages of treating the alcoholic to keep him from drinking or to prevent him from drinking, or to enable him not to drink. And I tell them it's comparable to paying an insurance premium each

morning to avoid catastrophe that night. And you can keep them on *Antabuse* as long as necessary — which may be years or days or months or whatever. So, this drug is certainly helpful in trying to get the alcoholic to desist from drinking, which is the only way that he's going to recover. Because once he is an alcoholic, he just can never drink any kind of alcohol again — beer, wine, hair tonic, cough syrup, Brown's mixture, *Geritol* they all contain alcohol.

*Dr. Singewald*: Dr. Klinefelter, what about sedatives if you have to use them during the acute episode? What do you use when you have to sedate somebody in the hospital?

*Dr. Klinefelter*: I was talking about giving them sedatives while they're drinking. Dr. Smoot, do you want to talk about what you use at Provident Hospital? You've had more experience than anybody here.

*Dr. Smoot*: Well, I don't know about that. The thing that I think has made detoxification a much less traumatic process than it was previously just by cold turkey alone is the use of the tranquilizers.

I have primarily used *Librium, Valium,* and one of the *Thorazine* derivatives, but I don't think that one has too much superiority over the others. The tranquilizers in themselves have been the thing that has kept down the agitation, which has been the most difficult thing that the personnel working with these individuals has had to contend with.

Usually on the first night that the patient is in the hospital, he might not sleep as well as you would think, or as one would expect, with large quantities of tranquilizers. But in addition to this, at bedtime we have a routine in which we give the patient about 500 mg of chloral hydrate.

There is one controversy as to whether you should use paraldehyde or not. I think Dr. Klinefelter and I agree that we don't feel that paraldehyde serves a good purpose here.

My reasoning here is that paraldehyde induces withdrawal symptoms just as alcohol does. The other thing is that paraldehyde goes through the same metabolic processes that alcohol does and what we are trying to do is break that pathway, so why substitute one for another? Another unpleasant side-effect, of course, is the odor.

But I haven't found any difficulty in using *Librium* and chloral hydrate. Usually within 48 hours these people are resting quietly. After three or four days they don't require too much in the way of sedation at night.

I also do not use too much phenobarbital or derivatives either, because I've found in a number of these cases — and I can't predict which ones — the patient becomes hyperactive. So our routine usually is 500 mg of chloral hydrate the first three or four nights and 100 mg of *Librium,* if necessary. Usually they are on 25 mg of *Librium* or 10 mg of *Valium* four times a day anyway. And this usually does away with the agitated state.

In the treatment of these alcoholics in a general hospital, the greatest problem comes when the physician who initially sees the patient or the one who is treating the patient doesn't recognize the possibility that alcoholism exists. And if you wait two or three days, they go into DTs. It has been our experience that the longer the time between the cessation of drinking and the institution of tranquilizers, the greater the chance of DTs and the more difficult it is to stop them.

*Dr. Singewald*: Dr. Klinefelter, would you like to add anything to that?

*Dr. Klinefelter*: Well, I would just like to add one thing. I don't think you should *ever* give alcoholics barbiturates, because they are just as apt to become addicted to barbiturates as they were to alcohol.

I don't believe this is as true with *Valium, Librium, Sparine,* and chloral hydrate, but it certainly is true with paraldehyde.

*Dr. Singewald*: Don H, would you agree with that?

*Mr. Don H*: I got so I loved paraldehyde, believe it or not. I couldn't comment in a technical sense. However, among alcoholics, and I suppose drug addicts, there's a certain cynicism. And you people are, it seems to me, well advised to counsel care.

*Dr. Singewald*: Now, are there more questions?

*Question*: Suppose I want to set up a chapter of Alcoholics Anonymous in my church, what does it take? Do I need a number of people who are pledged dry, or what?

*Mr. Don H*: Well, AA is not allied with any sect, denomination, organization, or religion. I'd suggest that you contact the AA Intergroup Office and discuss your needs with them. It isn't important whether the AA group would meet in your church or in an adjacent church. They are probably meeting in the neighborhood some place, which serves the same purpose. AA does not identify. But we do welcome the help of the clergy, and many churches offer meeting rooms to AA. AA accepts provided we can pay our own way.

I think your best bet if you want to locate an AA meeting is to call the AA Intergroup. If you have a problem with a parishioner, the Intergroup Office is a pretty good place to call. It might be that a good suggestion can be made.

*Reverend Shelley*: From personal experience in my old parish at the Church of the Guardian Angel, I saw the desperate need of having the fellowship of AA. I think we had 50 bars to one church. So I called AA and told them of my need and we started the Guardian Group. In fact the founder of the Guardian Group is sitting here in the audience tonight. Call 467-4667 and they'll help you.

*Question:* Is alcoholism genetically determined?

*Dr. Klinefelter*: I don't think that anybody has shown that it is genetically determined. But there isn't any question that there are clusters of alcoholics within family groups.

However, I think that some day somebody is going to be able to take a piece of litmus paper or some kind of paper and stick it in the urine of a newborn child and say, "This child is going to be an alcoholic some day if he drinks." Nobody has proven this yet. I just think this is going to happen.

*Dr. Singewald*: Dr. Beacham, we haven't heard from you yet. Would you like to tell us a little something about what services your organization has to offer?

*Dr. Beacham*: Before I go into the story of BACA I would like to make a general comment. I think the last few years have shown a dramatic increase in the alcoholic problem generally.

In 1968, our state was the first to pass a law whereby alcoholism was regarded as sickness. At first we had no money and then the state began to provide funds and things began to happen. I believe now we're at the point where we really don't know what to do next. I think we're uncovering more and more alcoholics. Whether we're helping them to recover in large enough numbers, I don't know. What I think is most exciting is the number of people, the number of groups that are getting into the act.

BACA, Baltimore Area Council on Alcoholism, is an organization almost 20 years old. For the last ten years it has been known by the present name. It's a voluntary organization and its functions are mainly information, education, and referral.

For the last few years it has spent much of its time helping the Division of Alcoholism Control with legislative activities and trying to get them support and money. This has been one theme, and the other has been to expand the areas of information and education.

The hospitals don't take alcoholics in voluntarily. By law they must accept alcoholics, and if they don't, then force could be used to get them in.

One of the things that has happened in the Baltimore Area Council is that we have expanded in several directions. A Medical Affairs Committee was started with the National Council on Alcoholism, and over the last couple of years we have invited various groups to join us to help act as a stimulus for the official agencies. In that group we have the University of Maryland represented.

We have just invited into the group an interfaith agency. The ministers we hope will join us and spread the word in their own group.

We have the Maryland Chapter of the National Association of Social Workers who joined us at our last meeting. We have invited a representative of the Alcoholism Counselors of Maryland, which will bring another large group of people into the fold. We have a representative of the Hospital Council of Maryland. The Medical and Chirurgical Faculty of course is represented here.

When this Medical Affairs Committee gets together we hope to join this wide variety of teaching agencies and scientific personnel and try to spread into the community more and more.

Another group that has been working over the last few years is an Industrial Advisory Committee. This group has attempted to get to the large working class. The members are not skid-row people, these are from the working public; and over these two years they have added members to the committee who are representatives at very high levels in management, and recently they have brought in labor so they can get to work as widely in the field as possible.

This group has had two sessions. At the first session, they had management representatives in. They took them to a place where they could get a television circuit which would watch the group acting out roles, and then they would play it back and show them what they were doing. Then this group went out into the industrial community and tried to sell programs of alcoholism control to the group.

The second session included labor representatives. They also went through role-playing and then went out into the community.

During the last few years we have obtained about 100 alcoholism counselors in the com-

munity. We started at one hospital. Most hospitals now have people that are available for alcoholism instruction.

The state police have a course in alcoholism education. The city police have some courses. We're also trying to approach the children.

The general approach is to get the teachers in groups and educate them so that they have better attitudes. This had already been done with physicians and staff in many hospitals. And now we're hoping the teachers will pass on the proper attitude to the children.

Last year, there were about 800 calls or consultations to BACA. I think it's of interest that about one quarter of the calls were from alcoholics themselves asking for help and about three quarters came from their families.

*Dr. Singewald*: Is Mr. Connolly in the audience? Would you mind saying something about your industrial program?

Mr. Connolly is with the Monumental Life Insurance Company and he can tell us first-hand what they do in their program.

*Mr. Connolly*: I think there's a common supposition that the alcoholic — we refer to him in lay terms as a drunk — is the fellow that's probably lying down here in Pratt Street. However, it probably won't come as a great surprise to learn that the highest incidence of alcoholism is with the clergy and the medical profession.

Less than 3% of the alcoholics are the typical skid-row bums — the one we all readily identify with — the fellow at the bottom rung of the ladder. It came as pretty much of a shock that we employ the other 97%; that every industry employs them; that firing them is no solution because the incidence of alcoholism stays at the same level; that probably 30% of our absenteeism is caused by alcoholism — the Monday hiders we call them in the office.

We had no program and the vast majority of industries here in town had no program. And to date we've only established a small nucleus in this area. But, we've got management interested. And just as importantly, we have labor interested and committed. And if we working together as a team can instill these programs in the various industries around the city, then we're going to go a long way in cooperating with the medical people and the clergy here in the city to effectively break this problem.

I think probably the most important thing is to bring it to public attention that it is a severe problem. We're talking in terms of nine million people in this country. Each one of these people



in turn affects a family and the family unit of three or four or even more people. And it's a very deep-seated, deep-rooted problem, and it's going to take us a good deal of work and cooperation. And I think we're just getting off the ground with the thing.

Our first approach was made, after our training sessions, to Lever Brothers. I think our reception was quite good. We're very hopeful that we can interest other large industries here in the city in uncovering the problem they have within the confines of their own plant. There are not millions, there are literally billions of dollars thrown away every year by industry because until now they have refused to face the problem.

Kennecott, DuPont, some of the more enlightened industries here in the city have seen the light and have done a tremendous amount of work within their own plants. They have also interested many of the rest of us in the possibilities and the potential of solving these problems.

*Dr. Singewald*: Dr. Bosma, I believe that you have been interested in the relationship between alcoholism in parents and difficulties that occur in children. In some cases people think that maybe youngsters go on drugs because their parents were alcoholics.

*Dr. Bosma*: I have been interested in this aspect for a long time. But recently I have been trying to read all the literature there is on this subject. In fact it's very interesting to find that there isn't very much.

There are also a few Al-Ateen groups in the city. I don't know how many. Perhaps the AA or Al-Anon member can tell you about that.

But it appears for one thing that the children of alcoholics have a great problem growing up in this type of a family. For one thing, one of the members is extremely erratic in his behavior.

Sometimes, let's say when he is sober, he may be a very loving and very positive parent, and at other times he may be very difficult.

And the second thing is that the mother is so preoccupied with the drinking of the spouse, providing help for the spouse, perhaps having to work because the money that comes in is rather minimal, that this half of the family quite often doesn't have much time to spend with her children. The wife becomes a martyr and her children sort of go by the wayside. As a result, we have found that the children of alcoholics are quite often rather disturbed children.

Now I do not believe, like Dr. Klinefelter, in the genetic or biochemical heritage of alcoholics. I believe that there may be a biochemical change during drinking. I don't believe that we will find a genetic difference, a gene that will cause people to become alcoholics. I believe that it's more environment and that it's a learned process.

It appears that the children of alcoholics have six times the chance to become an alcoholic than the children of nonalcoholics. I'm talking about one or two alcoholics as parents. It appears also that these children have a very frustrated and difficult youth. The main problem that they seem to develop is that they have an extreme inferiority complex, that they have a very low self-esteem which comes out in many ways, and one of the ways it seems to come out is in drinking alcohol, doing exactly the same thing that their parents did.

Of course you can say that may be genetic. You can also say that they perhaps incorporate the image of the parents. They get the idea that the only solution to the problems that people have is alcohol. You may also believe that it's the result of frustrations that cannot be coped with and are coped with by using alcohol.

The interesting thing that we have found lately is that of the drug abuses of the children, the majority of these children have alcoholic parents. I'm not talking about people that occasionally use drugs (marijuana). I'm talking about people that pop pills and use heroin. This would give you an indication that perhaps the genetic factor is not always important, otherwise they would definitely go on to alcohol because probably all these children have tried alcohol at one time or another.

Of course we also find that even when the alcoholic gets sober he has a problem relating. We find quite often the family is still rather shaky. And, sadly enough, we have been aiming and working toward getting the alcoholic sober in the hope that the rest will come by itself. We find then that there are alcoholics that replace alcohol with something else. And without wanting to put anything down, we find them going to meetings seven nights a week. Of course if you do that, you neglect your family.

Luckily enough, most of these people when they get into a treatment program usually don't have younger children any more. On the other hand, we are getting younger and younger alcoholics, probably because it's becoming a much more acceptable disease, people recognize it earlier, and they ask for help earlier.

But this is a problem I feel we really have to look at. I would really feel that AA and Al-Anon should make an enormous effort to create and develop more Al-Ateen groups and help the youngsters with their problems, because it's my feeling if we can help them in their teenage years, we might be able to prevent an enormous amount of alcohol and drug abuse in these youngsters.

And also the medical profession and all the helping professions together should perhaps aim and put more effort into helping the family so that the children have a more stabilized environment.

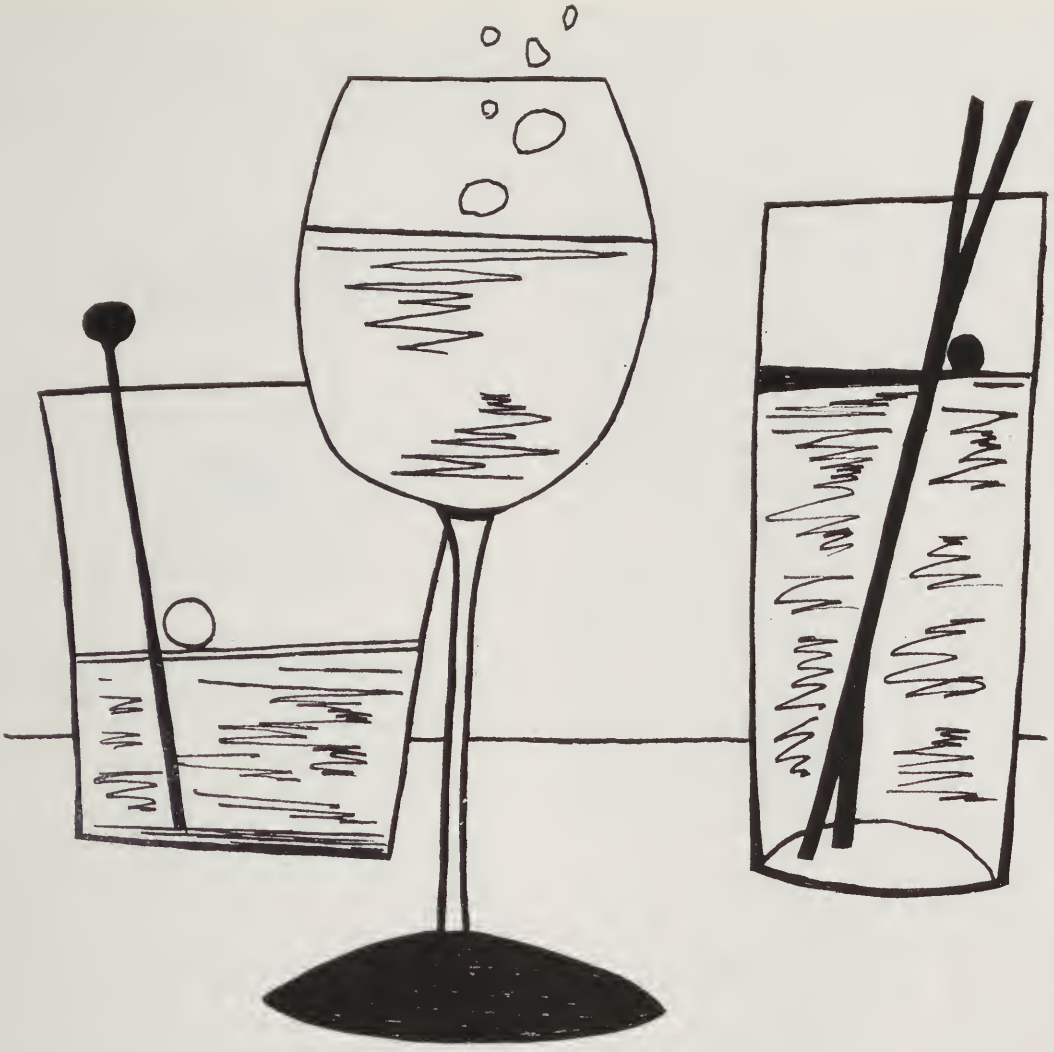
*Dr. Singewald*: Let me ask you a question before you stop. You said that a child in an alcoholic family has one in six chances of becoming an alcoholic. What are the chances of children of alcoholic parents becoming drug abusers as contrasted to becoming alcoholics?

*Dr. Bosma*: No, I said that the child with one or two alcoholic parents has six times the chance of becoming an alcoholic than a child of nonalcoholic parents. The only exception is that children of teetotalers have a much higher chance of becoming alcoholics than children of drinking parents that drink in moderation, which is a very interesting finding.

However, we don't have any concrete figures. The only thing that has been published, and it has been impressing the clinicians, is that they find many children that have alcoholic parents have severe problems with drugs. But this should be investigated. There are no statistics yet.

*Dr. Singewald*: Reverend Shelley, do you want to say something about clergy attitude about alcoholism? You have a wonderful quote about the alcoholic and what the church should be for the alcoholic: "The church is the hospital for sinners, not the museum for saints."

*Reverend Shelley*: That's not original. I heard that.



I think that the clerical attitude is very important because if a clergyman does not have an understanding of the problem, he can do more perhaps in deterring the alcoholic than he can to help him.

I really am thrilled however with the developments that are taking place now, and that seminarians are getting training in alcoholism.

They put on an excellent training program for seminarians who were going to St. Mary's Seminary here in Baltimore. These were future priests. Not only did they train them through didactic procedures about alcohol and alcoholism but, what's more important, they gave them an experience of actually working in the community with people.

These seminarians were associated with Echo House. They are still with Echo House and the Innercity Community Mental Health, satellite clinics, both of them — Carey Street, William Street, and also to Ward 2-F — the Tuerk House.

*Question*: I have had considerable experience in counseling tuberculosis patients who are also drinkers, and one of the things that I found out as we watched them was that as we would bring other members of the alcoholic's family in, I could seem to get much closer to the total group, especially to the alcoholic, when I discussed the problem of alcoholism with them.

And I was wondering how much effort we are expending to get the other members of the family involved, not as Al-Anon or Al-Ateen, but alcoholism families together. And I don't know whether you can bring children in. My attempt would be to get a family group together and discuss it, let them talk back and forth and see whether you can approach it.

This I guess must mean that the person will accept that he is an alcoholic in the first place.

I think Dr. Chafitz' study in Boston some years ago with homeless alcoholics found that the people that they were able to make some recovery with were men that they could get back to a family cluster.

*Dr. Bosma*: In my experience, I have found that it's a very good idea to bring the whole family in, even if the children are two or three years old, although it's much more helpful if the children are a little bit older and they're teenagers, which they usually are. (You know, it takes a while for alcoholism really to develop to the point where the people come for treatment.)

Family therapy, I think, is perhaps the most helpful. On the other hand, we have very few people who are willing to work with alcoholics for one thing. Secondly, we are very short in helping people *per se.*

*Dr. Singewald*: Dr. Young, would you say something about pastoral counseling? Dr. Young is the founder of the Pastoral Counseling Movement in this country.

*Reverend Young*: One of the training programs has already been mentioned, I believe, here in Baltimore. We take the seminarians into the hospital, say for a quarter in the summertime. Ideally I like the idea of a year's internship and sometimes two years.

Our program had closed circuit TV. The seminar members would sit around the table and watch the individual while he was counseling with the alcoholic he was assigned to, of course with the permission of the person involved. And then at the end of the session he would come down and join the group and spend 30 minutes discussing his counseling technique.

Now that is the ideal teaching method as far as I'm concerned. Like you say, you learn this thing by doing it. You don't lecture counseling to anybody.

*Question:* Dr. Young, why not get more people involved, if more people are interested?

*Reverend Young*: Well, I agree with you 100% in terms of dealing with the family. I was in a medical center and we set up an outpatient pastoral counseling service, and there was a home for alcoholic women there in the city and they asked us if we would do their counseling for them.

So these people that don't have their families with them, they're in this Friendship House, in this home for alcoholic women. I'm for the family idea 100%. I'd always do this if I could.

*Question*: I didn't mean just the family. I mean in addition to the clergymen, other members. There's nothing wrong with the clergymen and the physician, nurse, or counselor, or whoever is involved to get together in the group. I don't think this is a one-sided thing. I think we've been doing this too long.

Now maybe you can't get at large numbers except in group sessions this way. But we're beginning to get numerous enough where the alcoholic can hardly turn around without finding somebody interested in him and in alcoholism.

*Reverend Scott*: I agree with you but at the same time, you can't operate as a member of a team until you learn how to operate. And what I was talking about was training a man to do this —showing him how to counsel.

*Question (Dr. Snyder)* : Maybe this question is more for the clergy, but several things worried me.

I remember as a resident I had this alcoholic. He had a good job. He was in and out of the hospital. And finally he stopped drinking. Then he committed suicide.

This worried me. And to this day I sort of feel that alcoholism is a mental disease.

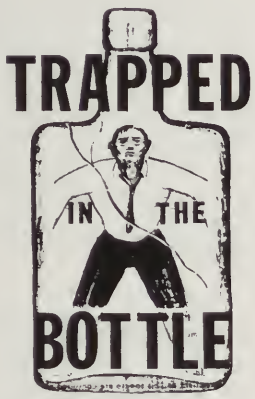
About 95% of the people in the United States can handle alcohol; if you have a cocktail party, everybody gets to work the next morning. I wonder if possibly as soon as a man is diagnosed an alcoholic, whether he should have psychiatric treatment? I don't know whether one of the panelists is a psychiatrist or not. But it has been my own personal experience in practice that when I send an alcoholic to a psychiatrist I get a high rate of so-called remissions, maybe not a cure. But there's no question but what if this man weren't drinking too much he would be using too much barbital and other drugs.

I examine at one of the state hospitals where they admit addicts. Whenever I examine somebody over 40 years old the chances are he's in for alcohol. When he's around 20 or 25 years of age he's in for drugs. And I think if these people could be picked up like the TB people pick up TB and really crack down on them and give them everything that they need, I believe this might help more.

*Dr. Singewald*: Dr. Bosma, as a psychiatrist, would you want to comment on that?

*Dr. Bosma*: Well, for one thing, the statistics were a little bit wrong. It appears that we have about 100 million adults in this country of which 30 million don't drink by choice, whether religious or any other reason. That leaves about

70 million people that drink. Of these 70 million people that drink, we have come to a figure of from six to nine million people that have a problem with alcohol. So that's indeed one in ten or perhaps even a little bit more, one in eight or nine.




Secondly, of course the problem in the treatment of alcoholics by the psychiatrist is for one that the alcoholic has definitely a very interesting division in personality, namely, when he is sober and when he is drunk. And we have even done studies in which it was found that if you teach an alcoholic or somebody that drinks heavily something when he is drunk, he won't remember it when he is sober but when he's drunk again he'll remember it again. And the other way around. Which means really if you would treat a man when he is drunk, when he sobers up he wouldn't have any benefit from the treatment. I don't know whether this is true, but that's how the feeling is.

The way psychiatry has been going about things for a long time has not been successful. It appears that the Freudian techniques and the Freudian approach are not helpful at all. It may be that some treatment in connection with conditioning and the learning theory may be helpful. We don't know.

There is an indication — and I feel rather strongly about it — that alcoholism is a learned disease. It is my feeling that the alcoholic, for one reason or another (and this is perhaps where the geneticists have an answer), uses alcohol as a defensive mechanism with the exclusion of most other defensive mechanisms. As a result, when he sobers up he is a rather poor person as far as his defenses go and it takes a long time for him to recuperate, and he has to stay sober. And it is our feeling that it takes about three to five years before a man is totally recuperated and can handle life psychologically and sociologically.

Now, Dr. Ruth Fox did an investigation of 500 alcoholics that had been sober for at least three years and 500 people from the street that didn't have any problem with alcoholism. And she found in this investigation, which was done quite a few years ago, that with our rather unsophisticated techniques of testing people in their psychological abilities that there was basically no difference between these two groups as far as mental disorders were concerned.

On the other hand, it is very clear that there are some disorders like inferiority feelings that are somewhat more common among alcoholics than other people, but these don't have to lead to inability to live adequately.

Now as far as suicide goes, I have a feeling that a certain percentage of alcoholics are suicidal and they drink suicidal, and perhaps if you might force them to stop drinking they might commit suicide in other ways. I have no answer and I don't know why that is. There are many people I have treated to whom I made it very clear that they were physically in such bad shape that I told them, "If you go on another bender, that may be the last one." Quite often it was. And they still went on the bender. And they were not stupid, you see. But I think they were suicidal.

*Question (clergyman)*: It seems to me, and I've encountered it in my number of years in the ministry, that people regardless of what the problem is have to be aware of the problem before you can help them.

How do you enter into a situation when people are not aware of it? This is my question.

*Reverend Shelley*: First of all, it's true that for a person to really want help he has to be aware he has a problem. But I think very often we can make people aware that they have a problem.

We heard a little while ago about industry. There's no law about a person drinking if he wants to, but if his drinking interferes with job performance, then industry has a perfectly legitimate right to say, "Wait a minute; your drinking is interfering with job performance and we suggest that you get to medical people and talk about this problem." So he is made aware of it in that way.

Another way that we're making them aware of it today is by having alcoholism counselors right in our courts. A man or woman is brought before the judge and at the basis of the charge is a drinking problem. It comes out in the evidence.

Several things may be done. The judge may put this person on probation on condition that he or she attends a treatment program. You know the old saying, you can lead the horse to the water but can't make him drink — but you can start putting a little salt on his tongue before he gets to the water to make him thirsty. And these are some of the things, through instructive coercion.

I was just reading this article by Dr. Ford, a Jesuit. It says that when you talk about drinking you have to be very delicate about the approach. He's criticizing the fact and I agree with him. If you have a parishioner and you know that he's in trouble with his drinking, and if you believe that alcoholism is an illness, why as a pastor can't you go see him and explain to him that you are there as a pastor, that he's a sick person and needs help. I've done this already to people right in the hospital. And it's good when they're in the hospital because they can't get away from me then, and I discuss the problem of alcoholism.

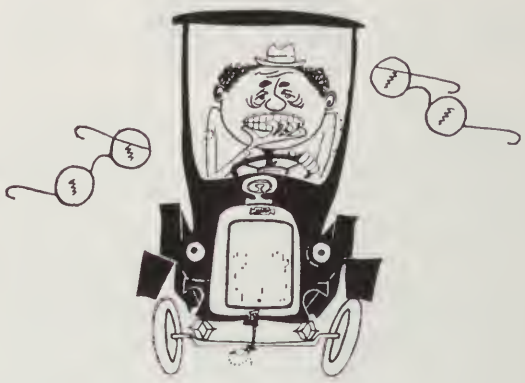
Now they may refuse it and they may tell you to mind your own business, but at least you've done your job.

*Question (Dr. Hirschfeld)* : Is there a statistical comparison as to how many physicians discharge their duties towards alcoholism as a disease; and how many clergymen discharge their duty to God in helping the alcoholic by making him understand that he does have a disease; and how many industrial leaders are really trying to improve their accident rate instead of hiding it and how many foremen in industry are trying to really uncover the alcoholic instead of covering him up? And how many members in the community expend tremendous sums of money in their notorious and unprecedented charitable acts to help causes which have long ceased to be a menace; and yet alcoholism is the third largest in morbidity? And Dr. Snyder meant that we should really attempt to hit the alcoholic by getting him to treatment because he has an emotional illness and he should really be in the hands of a psychiatrist.

Well, now, that one answer I had already in 1965 — an excellent psychiatrist, Dr. Schneidmuhl, who is the Director of the Alcoholism Center and has a marvelous program here for the city health department. He conducted a study for the Subcommittee on Alcoholism among the Maryland practicing psychiatrists and he found that there were only 8% interested in treating alcoholics. And then when we uncovered the anonymity of these 8%, we found that those 8% were the ones that were in institutions and we were treating them anyway.

So if we then answer Dr. Snyder and try to get enough psychiatrists, then we would have to have about ten psychiatrists for any nonpsychiatrist and then apply the 8% rule and we would still fall short in treating the tremendous number of alcoholics.

What I'm trying to bring togeher here is when you have a fund drive in Baltimore and you raise the measly sum of $4,000 and you get doors slammed in your face and you have prospective groups or captains fall down on their jobs, there's got to be something wrong with the disease we're dealing with. There is still the one thing that we haven't talked about, namely, sweeping it under the rug, and this is why we are having such difficulties.



There is something that wasn't brought up this evening. There are a number of private rehabilitation facilities and there are some psychiatric rehabilitation facilities. I would genuinely ask the question for the alcoholic, which is the better way to treat the alcoholic: in a specialized rehabilitation facility or somewhere where he is thrown in with other mental cases, drug addicts, and all the other types of mental illnesses?

*Dr. Singewald*: Dr. Lister is here from one of the private rehabilitation institutions.

Would you like to make a brief comment, Dr. Lister?

*Dr. Lister*: I do agree wholeheartedly that alcoholism is a learned disease from many aspects, although I question many of the other theoretical etiologies that are thought of and proposed. I do, however, believe that in treatment the best approach at this date is a learning process. And I do believe in a concentrated comprehensive effort given to alcoholics exclusive of all other diseases in a continuous run of group therapy so that they learn about alcohol, they learn about alcoholism, they have

some opportunity to develop an objective insight into their own role playing with that malady and learn all of the avenues of therapy. In my experience, this is the greatest approach to keeping people from revolving around detoxification centers.

*Question*: If you have a woman alcoholic and the family physician refuses to believe that the patient is alcoholic but you are quite certain of it, what would you do?

For instance, I recently had a patient who is superintendent of a large school, and has no clergyman or anything.

*Dr. Singewald*: I would answer that maybe you ought to get another physician.

If the physician is not interested, you might try to find one that is.

*Questioner*: Some of the physicians on this panel have even acted as if it is the man who is the alcoholic and the wife is going to Al-Anon. And setting this as nine million — we know that the woman alcoholic goes uncounted. I think we ought to put more emphasis on that in this session.

*Dr. Singewald*: They are harder to uncover.

*Mr. Don H*: AA had a survey in 1968, which covered the United States and Canada. It was scientifically conducted and I think the statistical data is pretty accurate.

Tweny-five percent of the AA people presently attending meetings are women. In some cities that figure was 50%.

In 1939 when the first 100 alcoholics published the big book of Alcoholics Anonymous, there were 99 men and one woman. They've been behind closed doors for years.

The woman alcoholic needs help because she carries a double stigma. She not only is an alcoholic but she's a drunk woman, and this is rough going. They are hidden, and when they come to us they have the double problem. And it's great to see so many of them coming. There have been some estimates and I can't vouch for these, that it's almost 50-50.

The sources of referral to AA are many and varied. But out of this survey came these figures on factors most responsible for attendance at the first AA meeting. Fifty-five percent of the people reported that it was another AA member. We don't know who (caused it), but this has to do with the twelfth step work. Thirty-four percent reported it was the family that had received information of some sort and the family got them to the first AA meeting.

In 1968, 16% said that it was the physician that got them to the first meeting and 7% said it was the clergyman.

With reference to the physician, for those newer people, 19% said it was the physician. The older people, that's people who have been sober for 15 years or so, about 12% said it was the physician. So there has been a terrific increase on the part of the medical profession and we're very grateful.

*Dr. Smoot*: We have had some interest in this program since we have had the detoxification unit in the hospital and it has been interesting to note that when we had a woman counselor we got more women as patients. When we had a man counselor we got more men as patients. But in looking over the women patients that we had, I think that there were more deep-seated psychiatric disturbances on the whole than there were in the men. And I think that there were one or two things that made this so.

One is that the husband is much less readily going to allow himself to believe that his wife is an alcoholic or wants anybody to find out about it. And, as a result, he would permit her to drink as long as she would stay in the house, so that there was really no way that she could get any help. And she was made to stay in the house. So these instances led us to get psychiatric evaluations on almost all of our women patients.

There are, I'm sure, a far greater number of women alcoholics than is realized, and I have missed the diagnosis in some for a long time, and I usually suspect it quite early.

Psychiatry, as I see it being practiced, isn't accomplishing what I would like accomplished and I don't know how to tell the psychiatrists to do better. But the one thing I think about alcoholism is that alcoholism and drug addiction are all really physiological and mental dependencies, and that we have got to find some way of breaking this.

Now I don't think that everybody who smokes has something wrong with them psychiatrically. This I think is the same type of a dependence and that really it is if you want to call it a mental problem but it should not be looked upon to be just treated by the psychiatrist. I think that all the branches of the medical profession can do as well. And as Dr. Hirschfeld said, you see there are only a very few psychiatrists who want to treat it, and I think that really there are very few physicians in the other specialties, but you will find them in each branch of medicine who are interested. So I

think that if we consider it more or less as a mental and physiological dependence we will be able to accomplish a little more.

*Question*: There are four organizations represented on this panel: two hospitals, Baltimore Area Council, Baltimore City Health Department. May I ask the panel to comment on the administrative aspects of this. I'm speaking about PBES and MIPES. PBES is the federal term, Program Planning Evaluation Budget System. And in Maryland, the Governor has supported the MIPES, Management Information Program Evaluation System. This calls for a statement of the problem, a series of activities in handling the problem, the budgetary aspects of how those activities are handled, and an evaluation of the effectiveness of those budgetary aspects.

Now we wondered if those four agencies might possibly speak on this statement of how to approach the problem.

*Dr. Bosma*: I'll try to answer that. Of course psychiatrists usually are very slippery and that's perhaps how I can manage.

The only thing I can say about the University Hospital is that at the present time there is no official budget associated with alcoholism or alcoholism services. We have in the hospital five counselors that are paid by positions of nurses and aides in the Psychiatric Institute. Their job classification does not exist officially at University although the state classifies them as alcoholism counselors. The rest of the services were created in connection with our educational program in which interns and medical students work in the emergency room and in some of the other facilities like our outpatient clinic and give service while they are learning about alcoholism. They work directly with the patients.

Now some of them, especially the ones that cover the emergency room in the evening, are paid by the nursing service a certain amount for each hour that they work. We don't have any personnel whatsoever to cover all the wards in the hospital, although the medical and surgical wards and the private wards have a counselor that comes by, also including one psychiatric ward.

We need much more personnel to give the service that we want to give and we definitely at the moment don't have any person now nor money nor time to evaluate our program.

*Dr. Singewald*: The state hasn't funded this too well, have they?

*Dr. Bosma*: The problem is in 1968 the law was passed about alcoholism and not a penny was at that time appropriated to implement the law, you know, to give the adequate services that the law said were necessary and needed. There are only a few dollars really that have trickled through since that time.

I think for next year the alcoholism programs will get something like $1 million and the drug programs will get about $3.5 million.

*Reverend Shelley*: In Baltimore City and also in the State of Maryland, the alcoholism programs are supported through Community Mental Health money of the State of Maryland, about 15% of the total Community Mental Health budget.

University Hospital, for example, receives Community Mental Health money for the operation of Tuerk House. The Hopkins and the Baltimore City Hospital programs also receive funds.

The Baltimore City Health Department program comes under mental health, and the budget for mental health of the Baltimore City Health Department at the present time is 50% local funds and 50% state funds. It is my understanding that there is a move towards all mental health programs being supported 100% by state funds.

Now at the Alcoholism Center itself, we have funding from various sources. The training program under the direction of Dr. Schneidmuhl and Mrs. Augustus is supported 100% by a federal grant under the National Institute of Mental Health. This is a training program for alcoholics and counselors. There are no local or state monies involved in this at all.

So far as the clinic program is concerned, it is supported 50% by the state and 50% by the city. So far as some of the staff on the center is concerned, they are supported by 100% grants from Community Mental Health money.

*Dr. Singewald*: Before we close, I want to give you the telephone numbers again: BACA — 366-5555; AA — 467-4667; Al-Anon — 823-1222.

We have tried to give you some helpful information but this is just the beginning. Remember, we are not supposed to cure every patient we see ourselves. The total welfare of the patient may have to be shared with others and with community resources which are increasing.

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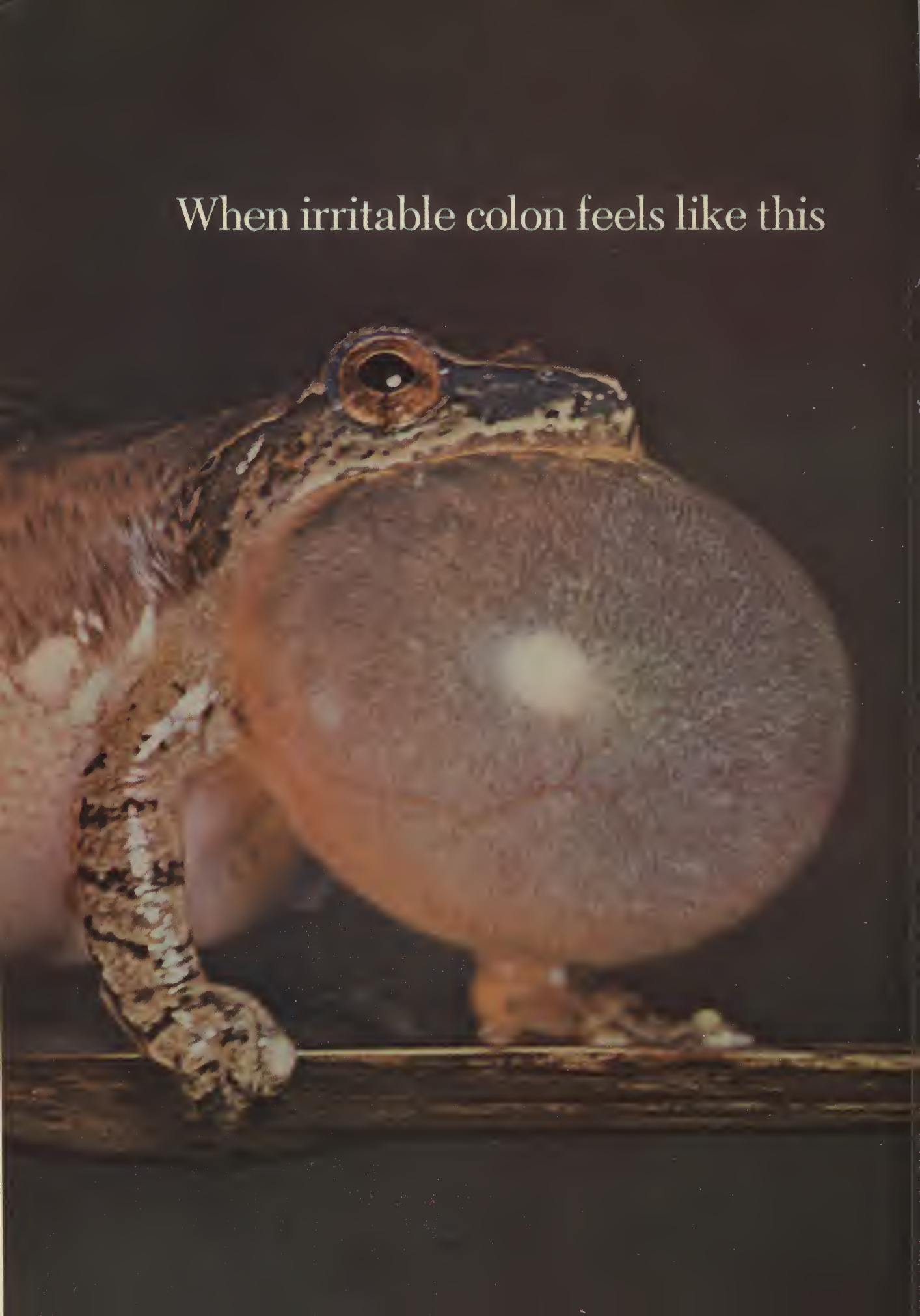
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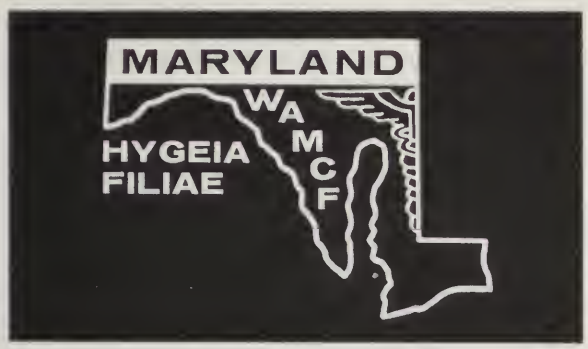
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MRS. WALLACE H. SADOWSKY, EDITOR

woman's auxiliary

# SEIZING THE TIMES

MRS. MARVIN L. KOLKIN
President-elect, Woman's Auxiliary
to the Medical and Chirurgical
Faculty of Maryland

In an effort to provide Auxiliary leaders from all over the country with the best possible aid in carrying out their duties, participants in the Annual AMA Auxiliary Conference in Chicago were privileged to be part of a most unique workshop this fall. Led by Richard E. Byrd, MD, president of a Minneapolis firm of Behavioral Science Advisors, we were taken through a highly-rewarding and thought-provoking program of personal and organizational development, aptly titled "Seizing the Times." Participating from Maryland were Mrs. Leonard Warres, Eastern Region International Health Activities Chairman, and Mrs. Marvin L. Kolkin, President-elect of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland.

The ultimate questions to which we sought answers were these: "Is our national auxiliary, through the implementation of its current programs and policies, relevant to the times in which we live? Are we preparing adequately for the future as well?" At the outset of the program, we set three goals. First, we hoped to develop self-insight. Secondly, we expected this self-insight to provide us with insight into the goals of the national auxiliary. And lastly, we hoped that this awareness would enable us to apply these insights for the betterment of our own state auxiliaries. In so doing, we hoped to be able to ascertain what our mission should be and how best we might be able to implement our goals.

By way of introduction to the task at hand, Dr. Byrd said: "All of us tend to act in certain predictable ways in our day-to-day living. Time after time we repeat the same patterns of behavior. Only in emergencies do we change these patterns. As we work in an organization, we use our daily behavioral patterns or styles like old shoes. They have their advantages. We are comfortable in them. Others know what to expect of us. Unfortunately, these styles can become the only ways we are able to act. Therefore, when new creative ideas or programs are introduced into the organization, the introducer has to risk the wrath, dismay, and confusion of having disturbed comfortable ways of working. "Seizing the Times" is risky business for it means changing the customary and comfortable.

"To explore the patterns of your organization we've designed a matrix of organization behavioral styles using the two dimensions of risk-taking (the force you put behind your ideas), and creativity. These styles suffer the oversimplification of all typologies. However, one gets a picture of the threat that people with creative ideas and inner-directed behavior cause to the conforming established norm of the organization. At the same time, it is easy to see the variety of people needed in organizations for appropriate stability in the face of change and innovation.

"Here, then, are some typologies of organization behavior which you may use to examine:

1) your own style,

2) whether or not you have a variety of styles within your organization,

3) what the organization styles tends to be, and

4) whether you are utilizing everyone's resources."

After determining our own "Creative Style," we then discussed the optimum directions in which we felt the Auxiliary should move in order to best "Seize the Times." We then explored our state auxiliaries to see if our own organization is made up of the kind of people necessary to "Seize the Times." We tried, then, to plan better ways to use these people or to recruit others so that we might move in the necessary direction. We asked of ourselves, "Are there changes we want to make? Are there people we need to bring into our organization to increase the risk-taking or the creativity of our organization? Are there people we must be sure have more support than they are now getting?" We were cautioned to bear in mind that at the county level, where the real work is accomplished, individual county needs, and cultural differences exist, and that we must tailor our overall objectives to allow for proper flexibility. To do this and still move in the direction of our overall goals and missions is, of course, the ideal.

It is hoped that a review of this program at next year's Fall Conference will be beneficial in assessing the net worth to our state auxiliaries of this most stimulating approach.

Bearing out the fact that our Auxiliary is indeed attuned to the times was the choice of our other guest speakers and the content of their remarks.

The Honorable Richard Fulton, Democratic Congressman from Tennessee, and one of the more than 150 sponsors of the AMA's Medicredit bill, addressed the conference. He discussed the medical and health care bills now under consideration by the House Ways and Means Committee, of which he is a member, and he expressed the hope and belief that legislation acceptable to the physicians of the nation will emerge.

Ernest B. Howard, MD, Executive Vice-President of the AMA, discussed the current health problems facing us. He predicted that in five to ten years the supply of physicians will catch up with the demand. Until that demand is met, however, it is vital that we continue to provide availability of and access to medical care for all citizens. Dr. Howard feels that increased use of emergency rooms is not the answer to the problem of the current doctor shortage because, he feels, they cannot replace the primary physician. He does feel, however, that the increasing use of nurses and medical assistants by the primary physician will enable him to care for greater numbers of patients. Dr. Howard, too, expressed the belief that the National Health Insurance Act which will become law will be one which the medical profession can accept. He fully expects that it will permit physicians to retain the high quality of the care they render and will provide for the fee-for-service system now in existence. Parenthetically, Dr. Howard pointed out that in Germany the people and the labor unions alike fought to return to a fee-for-service system and are now enjoying far better health care.

We were also privileged to hear Max H. Parrott, MD, Chairman of the AMA Board of Trustees, who assured us that the AMA needs and solicits Auxiliary help. He advised us of the three areas in which he felt the women could serve most effectively: politics, legislation, and membership. Dr. Parrott emphasized that there is strength in unity and urged doctors and their wives to join the AMPAC movement, which supports political candidates sympathetic to medicine. It was reiterated that we may expect many features of the AMA's Medicredit bill to be included in the evolving medical legislation.

Our conference included "Mini-workshops" in the fields of Health Education, Health Manpower, International Health Activities, and Volunteer Health Services.

We concluded with a tour of the AMA headquarters and the viewing of some excellent films which are available on loan through the AMA. Outstanding were the film explaining Medicredit and a movie called "Drugs are Like That," geared for viewing by third and fourth graders.

In summary, I submit that this Annual Leaders' Conference of the AMA Auxiliary was indeed outstanding and an indispensable aid to those charged with carrying out Auxiliary activities on the local level. The high quality of the program and the superb caliber of the persons presenting the various sessions give the assurance that we can and will be an effective instrument in carrying out the important tasks confronting us in behalf of good medical care.

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# Baltimore City Medical Society

## November Minutes

The Board of Directors of the Baltimore City Medical Society met on November 9 at 1211 Cathedral Street, Baltimore, at 4:30 PM. The meeting was called to order by Philip Wagley, MD, President. The minutes of the October 12 meeting were read and were approved by the Board.

The first item on the agenda was the approval of a supplemental budget submitted by Richard London, MD, Treasurer.

SUPPLEMENTAL BUDGET FOR OCTOBER, NOVEMBER, DECEMBER 1971

| | |
|---|---|
| Meeting Expenses | $ 200 |
| Miscellaneous | 500 |
| Postage | 1,000 |
| Printing | 1,000 |
| Telephone | 300 |
| Total | $3,000 |

The Society is presently running at a deficit of $146.60 through the end of October. The increases in postage and printing are due to the increased activity of the Society in holding over twice as many committee meetings this year as in previous years, plus the cost of the special meeting. Increases in expenditures have also occurred in the area of the cost for hiring an additional employee, travel expenses, and telephone — none of which were budgeted.

It is also necessary to bring the books into line with the Bylaws. The books for some years have been closed on November 30 but, according to the Bylaws, the fiscal year should be from December 31 to January 1. The budget which was approved last year was for a fiscal year from December 1 to November 30. Therefore, it is necessary to approve the budget for the month of December this year and have the budget which was approved at the last meeting become effective on January 1.

The next item on the agenda was notification from Mr. Chad B. Combs, Assistant Director of the Division of Public Affairs of the American Medical Association. Mr. Combs expressed his satisfaction at the agreement of the Baltimore City Medical Society to submit to a survey. Mr. Combs suggested that if the Baltimore City Medical Society was in agreement that the survey would begin in early January or February. The details would be worked out with Mrs. Silk.

The Policy and Planning Committee submitted the following recommendations which were approved by the Board:

1. The Committee discussed the possibility of establishing a program for the orientation of the wives of foreign medical residents to acquaint them with the social and economic problems of life in Baltimore City through representatives of the Baltimore Council for International Visitors and the BCMS Woman's Auxiliary. It was stated that the Woman's Auxiliary might be interested in establishing a program and it is requested the Board of Directors to formalize this by writing to the Auxiliary urging that such a program be arranged for the coming year.
2. In discussions of the problems encountered by foreign physicians, the committee's attention was drawn to the fact that foreign physicians who wish to enter practice in this country are not informed of the basic economic facts which are necessary to operate a medical practice. Therefore, the Policy and Planning Committee recom-

mends that the Baltimore City Medical Society sponsor a meeting shortly after the Board of Medical Examiners licensure examinations are completed twice each year to orient foreign physicians in economic and ethical problems which are encountered in practice in this country. It is suggested that representatives from the Internal Revenue Service, an expert on medical economics, and representatives of Blue Cross-Blue Shield be invited to these meetings. It is further recommended that a committee be established composed of foreign-born physicians within the Society to formulate the program content for the meetings. The program should be open to all foreign medical graduates, regardless of Society membership.

The Board requested the Policy and Planning Committee to formulate a list of topics to be covered, and detailed plans for such a seminar.

3. An Ad Hoc Committee was to establish lines of communication between the Society and the Department of Social Services for the discussion of mutual problems. These lines of communication have now been established and it is recommended that a committee be appointed to continue hearing problems as they arise. It is recommended that the persons serving on the Ad Hoc Committee be appointed to a Liaison Committee with the Department of Social Services.

The next item on the agenda was a recommendation for nomination for the Health and Welfare Council Organization Achievement Award. Harry Klinefelter, MD, nominated the Baltimore City Health Department's Alcoholism Counselor Training Program. The Board of Directors unanimously agreed to this nomination and requested Dr. Klinefelter to formulate a detailed resumé of the project for submission to the Health and Welfare Council.


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# Letters to the Editor

*Editor's Note: The "Urban Health Challenge: Survey of Physician Manpower in Metropolitan Baltimore" scientific article by Eric M. Fine, MD, in the October issue of the Journal caused quite a flurry of activity. Dr. Fine was taken to task by M. K. Gorten, MD, Assistant Commissioner of Health, Baltimore City Health Department. His letter to the editor and Dr. Fine's reply are printed here in order that you may draw your own conclusions and to correct any erroneous impressions that the original article may have engendered.*

## DR. GORTEN

Reference is made to Dr. Eric M. Fine's article on "Urban Health Challenge: Survey of Physician Manpower in Metropolitan Baltimore," *Maryland State Medical Journal,* Vol. 20, Page 67, October 1971. I do not aim to detract from Dr. Fine's scholarly presentation of a very important subject, but his article illustrates some of the pitfalls involved in comparing two sets of data, strikingly exemplified by the fact that the two sets of data both originated from the same source — the Medical Care Service Section of the Baltimore City Health Department.

The author used the published results[1] of our physician manpower data from 1967 and compared these findings with our January 1971 physician referral listing.[2] Dr. Fine's findings are shown in the table at the bottom of page 68 of the cited Journal. The columns giving the number of physicians and the rate per 100,000 population in 1970 in Baltimore City and the five counties are erroneously constructed. These counts, coming from our physician referral listing, are counts of professional addresses, not of physicians.

*Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgment. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL,* 1211 *Cathedral Street, Baltimore, Md.* 21201.

The referral listing lists a physician at each of his professional locations. In the listing, after the physician's name and address, the *address sequence* and *total addresses* are indicated. Thus, for each entry there is information about how many professional addresses the physician has and which address (primary, secondary, etc) is given; to find the number of physicians it is necessary to count each physician only once, and at his primary address.

The second point to be made, and one that all of us can benefit from, is that authors ought always to seek out readers for proposed articles. In this case the errors in interpretation could have been quickly eliminated. The Table with this reply contains the correct counts.

It is my hope that the erroneous information in the article can be changed promptly by Dr. Fine to avoid current and future misunderstandings.

Martin K. Gorten, MD
Asst. Commissioner of Health
Baltimore City Health Dept.

REFERENCES


1. McMillan AW, et al: Assessing the Balance of Physician Manpower in a Metropolitan Area, PHR Vol 85 No 11, November 1970.
2. Baltimore City Health Department, Physician Referral Listing, Baltimore, January 1971, (Computer-Printout).


**Table 1: Location and number of practicing physicians, Baltimore SMSA, 1967-1970.**

| | 1967 | | 1970 | | 1967-70 |
|---|---|---|---|---|---|
| | Physicians | MD/ 100,000 | Physicians | MD/ 100,000 | MD/100,000 Percent Change |
| Baltimore City | 1,457 | 159 | 1,547 | 171 | + 7.5 |
| Anne Arundel County | 120 | 44 | 166 | 56 | + 27.3 |
| Baltimore County | 390 | 68 | 473 | 76 | + 11.8 |
| Carroll County | 49 | 80 | 53 | 77 | − 3.8 |
| Harford County | 53 | 52 | 57 | 49 | − 5.8 |
| Howard County | 16 | 31 | 22 | 36 | + 16.1 |

# DR. FINE

First, I would like to thank Dr. Gorten for reviewing and correcting the data presented in Table 1 of my article, "Urban Health Challenge: Survey of Physician Manpower in Metropolitan Baltimore." The tabulated figures cited in the letter by Dr. Gorten are correct and official. However, in reviewing these data and their source, I find that an explanation of the discrepancies and several additional observations are indicated. In the 1970 *Physicians Referral Listing,* the data were based upon counts of professional addresses, not of physicians, as is clearly indicated in the instructions accompanying the listing.[1]

McMillan also describes that, ". . . physicians with several office locations were listed in all appropriate census tracts . . ."[2] for the projected computerized file. The 1967 data were based upon McMillan's published version of the 1967 Physician Manpower Survey for which the methodology was assumed to be the same. Careful review of McMillan's method fails to reveal how multi-location physicians were tabulated, and I appreciate Dr. Gorten's bringing this discrepancy to my attention.

The question of enumerating practitioners by office location(s) versus as individuals is intriguing. From the point of view of simple availability of services, the single physician with several office locations might be available to more neighborhoods and patients than the practitioner with a single location. The careful comparison of these two configurations should be investigated. Dr. Gorten's figures of 1970 physicians compared with those derived from 1970 physician-location suggest that practitioners with multiple offices accounted for 366 additional locations within the Baltimore Standard Metropolitan Statistical Area receiving primary care. This is 15.8 percent higher than estimates derived solely from numbers of individual physicians and may more accurately depict the manpower situation.

The central thesis of this article remains unchanged. Data derived from the American Medical Association Directories,[3,4] which is not subject to the vagaries of definition described above, clearly demonstrates the net loss of practitioners from the low-income and low-rent areas of Baltimore City. This trend has been amply documented in other urban centers and can no longer be ignored. In the words of Dr. William L. Kissick, "The options for the physicians are these: to seize the initiative and help shape the future, or to have the future shaped for them."[5] The challenge stands.

Eric M. Fine, MD
Instructor
Department of Pediatrics
University of Maryland
School of Medicine
Baltimore, Maryland 21201

REFERENCES

1. Baltimore City Health Department, Physicians Referral Listing, Baltimore, January 1971, (Computer Printout).
2. McMillan AW, et al: Assessing the Balance of Physician Manpower in a Metropolitan Area, Public Health Reports, Public Health Service, U S Dept of Health. Educ & Welfare, Vol 85 No 11, 1970.
3. American Medical Association, 23rd Directory Part II, Chicago, 1965.
4. American Medical Association, 25th Directory Vol II, Chicago, 1969.
5. Kissick WL: Health Policy Directions for the 1970s, New England Journal of Medicine, 282:1343-1354, June 11, 1970.

# Medical Education Changing

Traditional medical education programs are undergoing changes in the United States.

This is the observation of Samuel B. Guze, MD. The vice chancellor of Washington University's School of Medicine said the development might well reverse a trend which characterized medical schools since the 1910 Flexner Report. This report forced many medical schools to close and made others upgrade and standardize their curriculums.

"I think we are entering a new phase in which schools are changing their programs independently . . . each one may become different." Dr. Guze said.

"Especially since the end of WWII medical schools have become more uniform," he continued. He added, "The diversification can help stimulate progress, but some schools may find their standards suffering."

Several factors may be attributed to this sway away from traditional medical school programs. They include the growth of specialists and the resulting shortage of general practitioners; the shortage of all physicians (a point debated by physicians); the realization that no one person can absorb all the factual data known today and a movement toward earlier contact with patients by medical students.




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House in the Pines Nursing Homes ..... 98

Eli Lilly & Co., Inc. ..... 7

Merrell-National Labs. ..... 31-32

Monarch Lincoln Mercury ..... 89

Wm. P. Poythress Co., Inc. ..... 44, 53-54

T. Rowe Price ..... 27

Public Service Vehicle Equipment Leasing ..... 48

Geo. Radebaugh & Sons ..... 13

Read's Drug Stores ..... 90

Roche Laboratories ..... Covers 2 & 4, 1, 22-23

Roerig & Co. ..... 24

Manuel Schwartz Hearing Rehabilitation 92

G. D. Searle Co. ..... 42-43

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Special Diet Shop ..... 35

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Mano Swartz—Furs ..... 10

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Tio Pepe Restaurant ..... 90

Towson Valley Motors ..... 95

Upjohn Co. ..... 28-29, 64-66

USV Pharm. Corp. ..... 63

D. Stuart Webb Advertising Services, Inc. 92

Wallace Pharmaceuticals ..... 26

White Rice Inn ..... 90

Vera Woods Personnel Service ..... 92

Zimmermann's Shoes ..... 10

# Index to Vol. 20

## *Maryland State Medical Journal*

**January-December 1971**

## SUBJECT INDEX


**Abortion**

GUTTMACHER AF: Changing attitudes and practices concerning Abortion: a socio medical revolution Dec 59-63

**Alcoholism**

Alcoholism, industry and public health May 93-5

AUGUSTUS G: Maryland program for training alcoholism counselors Jul 119-21

BOSMA WGA: An example of alcoholism treatment in the United States Aug 81-4

BRADLEY NJ: Treatment of acute intoxication: part 2 Jan 102-04

ESTERLY RW: The drunken driver in the alcoholic rehabilitation program Nov 71-2

The alcoholic rehabilitation program in the Prince George's county division of parole and probation Oct 81-4

FARBER RE: New alcoholism service Sep 65

HOOVER EP: Incidents of alcohol and drug related arrests Apr 99-101

HURLEY CW: Alcoholism: a social study on 200 patients Sep 71-2

LISTER LM: Inpatient alcoholic rehabilitation care May 33-5

QUEEN D: Attitudes and skills of the nurse in working with the alcoholic and his family June 83-5

READING AJ, BROWN TC: Interdisciplinary alcoholism education for medical and paramedical personnel Mar 85-8

SHENKHAM M: How to take a history on an alcoholic Feb 93-5

SJOLUND GC: Women's alcoholic rehabilitation unit utilization in demographic data Dec 42-5

**American Medical Association**

COMBS C: AMA's medicredit proposal Aug 18-19

**Amputation**

WILLIAMS GR: Replantation of amputated extremities: present status Dec 64-8

**Asphyxia**

MIHALAKIS I: Asphyxia from pacifier Mar 53-4

**Baltimore City Medical Society**

Jan 19-20
Feb 51
Apr 49-50
May 19-20
June 15-16
Jul 15-16
Sep 13-14
Oct 12-13
Dec 32

**Baltimore County Medical Society**

Mar 15
Aug 13
Sep 35
Dec 33

**Blood**

GRINDON AJ: Maryland law and blood transfusion June 55-8

PETRUCCI JV: Red cell (Packed cell) transfusions: an appeal to reason Jan 61-2

**Brain**

COHEN BS: Use of physical therapy in neurological disorders Dec 53-6

**Cancer**

BEAZLEY RM: Etiological aspects of carcinoma of the colon Sep 49-51

**Chest**

MORGAN WK: Useful symptoms and signs in chest disease Sep 58-60

**Coccal**

WALKER SH, GONZALES EP: Cephalexin: effective oral antibiotic for coccal infections Jan 63-5

**Colon**

BEAZLEY RM: Etiological aspects of carcinoma of the colon Sep 49-51

**Dentistry**

FARBER RE: Mobile dental units planned Feb 85

PUSHKIN PH: Overview of fluoridation Jan 73-6

**Drugs**

DAVIS EP, PARNES JN: Case for success in narcotic drug addiction May 63-5

HOOVER EP: Incidents of alcohol and drug related arrests Apr 99-101

**General Practice**

STEWART WL, ENTWISLE G: Task performance and task delegation in general practice Aug 67-73

**Health**

DE HOFF JB: Vanishing diffuse outpatient department Mar 44-9

FARBER RE: Baltimore's health highlights for 1970 Mar 97-100

Dr. De Hoff appointed chairman of national Health Records Committee May 81

Highlights, Baltimore City Health Dept. June 39 Jul 137 Dec 41

New clinic in South Baltimore Aug 51

FINE EM: Urban health challenge: survey of physician manpower in metropolitan Baltimore Oct 67-71

GORWITZ K, WARTHEN FJ: Maryland faces the 1970s Feb 64-8

HENZE, WA: The People's Free Medical Clinic Jul 58-9

SOLOMON N: Home health services in the care of the chronically ill Jan 79

Maryland State Dept. of Health, Highlights Dec 14

**Heart**

BODENHEIMER M, KOTLER MN: Echocardiography of the mitral valve Oct 50-2

COHEN BS, GRANT A: Rehabilitation and acute myocardial infarction Sep 67-70

COHEN ML: Continuous portable EKG monitoring June 71-3

COOPER M: Radionuclides in clinical cardiology Nov 28-30

HAMMERMEISTER KE, BELCHER HV: Acute streptococcal pericarditis: report of a case treated with pericardiectomy June 50-4

HUMPHRIES JO: Atrial septal defect in the adult Mar 89-90
KELLY DT: Aortic stenosis Dec 73-4
KOTLER MN, TABATZNIK B: Significance of ventricular dysrhythmias in men after myocardial infarction Jul 127-8
MCLAUGHLIN JS, BLACKFORD J: Homograft heart valves Apr 83-4
MULHOLLAND JH: Antibiotic treatment of bacterial endocarditis Feb 89-91
PARISI AF, SCHECHTER E: Systolic intervals for evaluation of left ventricular function Jan 81-3
ROGUE JL: Mechanism of action of thyroid hormone on the heart Sep 75-7
SMOLKIN C, COHEN BS: Vocational evaluation and the stroke patient: a discovery of self Nov 60-2
SPENCER FC: Bypass grafting for occlusive disease of the coronary arteries May 68-73

**Hepatitis**
CAVENAUGH RL: Testing for hepatitis-associated antigen Jul 129-30

**Hospitals**
CARROLL DG: Patterns of medical care in a municipal hospital intensive care unit: convenience or necessity? Jan 89-94
Part 2 Feb 38-40
Prediction of rehabilitation accomplishment in a chronic disease hospital Mar 93-5
Readmissions to an acute medical service Apr 89-92
Part 5 May 87-9
New guidelines for admission of the aged to state mental hospitals June 37-8
Sheppard and Enoch Pratt Hospital Dec 5

**Immunization**
GARBER HJ: Immunization requirements for travelers Jul 130-2

**Lungs**
CONROE JH, NADEL JA: Screening tests of pulmonary function Jan 95-6
GOLD MI: Respiratory failure: failure or success? Feb 57-8
PARKER JD, et al: Treatment of chronic pulmonary histoplasmosis Apr 93-4
REDDY P, et al: Progressive disseminated histoplasmosis as seen in adults Feb 77-8

**Marriage**
FARBER RE: Interracial marriages in Maryland Jan 85

**Medical and Chirurgical Faculty**
SARGEANT J: Executive Director's Newsletter pp 9-10 each month
Your Medical Faculty At Work
Jan 77-8
Feb 69
Mar 55
Apr 76
May 74
June 65
Jul 116-18
Oct 36-40
Nov 7
Dec 15

**Medical and Chirurgical Faculty, Business**
Annual Meeting: Jan 38-40; Feb 26-8; Mar 68-9; Apr 32-3
Scientific Exhibit Winners Dec 23

**Medical and Chirurgical Faculty, Library**
Library page:
Jan 99-101
Feb 75-6
Mar 77-9
Apr 25-6
May 79-80
June 87-90
Jul 51-2
Aug 47-9
Sep 81-3
Oct 86-9
Nov 91-3
Dec 46-8

**Medical and Chirurgical Faculty, Transactions**
Minutes of 173rd annual session, House of Delegates Jul 35-40
Annual reports to the House Jul 67-100
Annual financial statement July 101-113
Woman's Auxiliary Jul 114-15
Report of Peer Review Committee to the House of Delegates Nov 76-90

**Medical Assistants, Association of**
Highlights: Jan 53 Apr 77 May 27 Aug 27 Nov 13

**Medical Education**
ROSE TG: Medical education in the 70s: what the student wants Jul 56-7
VASH PD: The new medical student Jul 61-2
WAGLEY PF: What medical students think is wrong with medical education today Jul 55
WEINSTEIN H: Changing attitudes of medical education and its ramifications upon the student Jul 59-61

**Medical Examiners, Board of**
Addendum to Directory: Apr 23-5 Dec 78-84

**Medical News**
Jan 41-3 49-51
Feb 33-7
Mar 23-5 35-8
Apr 21-3 37-8
May 29-30 37-40
June 34-6
Jul 31-2 47-9
Aug 31-2 40-1
Sep 24-5 29-30
Oct 23-5 33-5
Nov 5-6
Dec 6-13 93-4

**Medical Professionalism**
Abandonment defined Jan 13
FARBER RE: Health corporations: a new approach for health manpower, cooperation and care Nov 16-17
FINE EM: Urban health challenge: survey of physician manpower in metropolitan Baltimore Oct 67-71
Professional ideals May 13
ROSENOW EC Jr: Medical knowledge self-assessment program Dec 69-71
SCHAEFER JF: Medical ethics Mar 42-3
STEWART WL, ENTWISLE G: Task performance and task delegation in general practice Aug 67-73

**Medicine, History**
CARROLL DG: Medicine in Maryland, 1634 to 1835 Feb 59-63
Medicine in Maryland in the 17th and 18th centuries Sep 52-7

**Medico-legal**
COCCO AE: Peer review in the state of Maryland Apr 53-7
GRINDON AJ: Maryland law and blood transfusion June 55-8
SOLOMON N: Major legislative proposals—1971 Mar 83-4

**Mental Health**
VEISER EM: Lithium carbonate treatment in the manic-depressive and predictability of outcome of treatment May 66-7
New guidelines for admission of the aged to state mental hospitals June 37-8

**Muscles**
SOPHER IM, ROSENHOLTZ MJ: A case of isolated papillary muscle infarction with rupture Jan 68-72

**Occupational Medicine**
HALPERIN HJ: How to diagnose occupational disease Aug 75-6
Occupational and environmental health news Feb 79-80

**Plastic Surgery**
Founding of the John Staige Davis Society of Plastic Surgeons of Maryland, Inc Sep 15

**Podiatry**
COHEN AR: Practice of podiatry in the state of Maryland Jan 66-7
FARBER RE: Podiatry clinic in western health district building Apr 85

**Poisoning**
FARBER RE: Child lead paint poisoning Aug 51

**Politics**
Maryland medical political action committee Aug 17-18

**Pregnancy**
ERKAN KA, et al: Juvenile pregnancy role of physiologic maturity Mar 50-2
HELLER RH: Prenatal diagnosis and the prevention of birth defects May 59-62
KELLOGG DA: A psychiatric syndrome in women evaluated for an unwanted pregnancy Oct 75-8

**Puerto Rico**
MANUZAK HF: Puerto Rico: Diary of a summer vacation in the winter June 59-64

**Rehabilitation**
CARROLL DG: Rehabilitation notes June 67-8
FLEISCHER CJ: Ambulation aids Oct 57-61
HALPERIN EJ, COHEN BS: Perceptual-motor dysfunction stumbling block to rehabilitation Jul 139-41

**Sports**
BERKOW JW: Preservation of sight in sports Nov 57-9
BUSKIRK ER: Stress limits in the young athlete Nov 35-7

**Surgery**
BUXTON RW: Conduct of an operation Aug 59-66
COHEN BS: Use and misuse of physical therapy modalities in the treatment of athletic injuries Nov 48-51
COLEMAN RC Mrs: Sports and physical fitness programs for girls of western Europe compared with those in Maryland Nov 38-40
LAVINE SA: Field diagnosis of athletic injuries Nov 45-7

**Thyroid**
ROGUE JL: Mechanism of action of thyroid hormone on the heart Sep 75-7

**Ticks**
CRAWFORD KL: Ticks Nov 95-6

**Toxoplasmosis**
CRAWFORD KL: Toxoplasmosis Aug 77-8

**Tuberculosis**
FARBER RE: TB X-ray drive; new TB-alcoholism service Sep 65
TB testing project achieves results Jul 135-6
VALL-SPINOSA A, et al: Rifampin in the treatment of drug-resistant TB June 79-80
YOUNG RL, et al: Pulmonary sarcoidosis: a prospective evaluation of glucocorticoid therapy Mar 101-02

**Urology**
ENGEL RM, SCOTT WW: Hypospadias: experience with a new one-stage repair (Hodgson urethroplasty) June 45-9

**Viral disease**
DEINHARDT FW: Symposium on viral diseases: hepatitis Apr 59-62
FRIEDMAN RM: Antiviral agents Apr 70-5
JOSEPH JM: Laboratory diagnosis of viral diseases Apr 63-9

**Woman's Auxiliary**
Mar 29
Apr 81
June 27-9
Jul 45-6
Aug 55
Sep 45-7
Oct 16-17
Nov 14-15
Dec 28-30

# AUTHOR INDEX

AUGUSTUS G: Maryland program for training alcoholism counselors Jul 119-21
BEAZLEY RM: Etiological aspects of carcinoma of the colon Sep 49-51
BEISER EM: Lithium carbonate treatment in the manic-depressive and predictability of outcome of treatment May 66-7
BELCHER HV: See Hammermeister KE
BERKOW JW: Preservation of sight in sports Nov 57-9
BLACKFORD J: See McLaughlin JS
BODENHEIMER M: Echocardiography of the mitral valve Oct 50-2
BOSMA WGA: Example of alcoholism treatment in the United States Aug 81-4
BRADLEY NJ: Treatment of acute intoxication: part 2 Jan 102-4
BROWN TC: See Reading AJ
BUSKIRK ER: Stress limits in the young athlete Nov 35-7
BUXTON RW: Conduct of an operation Aug 59-66
CARROLL DG: Medicine in Maryland in the 17th and 18th centuries Sep 52-7
Medicine in Maryland, 1634 to 1835 Feb 59-63
Patterns of medical care in a municipal hospital intensive care unit: convenience or necessity? Jan 89-94
Part 2 Feb 38-40
Prediction of rehabilitation accomplishment in a chronic disease hospital Mar 93-5
Readmissions to an acute medical service Apr 89-92
Part 5 May 87-9
Rehabilitation notes June 67-8
CAVENAUGH RL: Testing for hepatitis-associated antigen Jul 129-30
COCCO AE: Peer review in the state of Maryland Apr 53-7
COHEN AR: Practice of podiatry in the state of Maryland Jan 66-7
COHEN BS: See also Halperin EJ and Smolkin C
Use and misuse of physical therapy modalities in the treatment of athletic injuries Nov 48-51
Use of physical therapy in neurological disorders Dec 53-6
COHEN BS, GRANT A: Rehabilitation and acute myocardial infarction Sep 67-70
COHEN ML: Continuous portable EKG monitoring June 71-3
COLEMAN, RC Mrs: Sports and physical fitness programs for girls of western Europe compared with those in Maryland Nov 38-40
COMBS C: AMA's medicredit proposal Aug 18-19
CONROE JH, NADEL JA: Screening tests of pulmonary function Jan 95-6
COOPER M: Radionuclides in clinical cardiology Nov 28-30
CRAWFORD KL: Ticks Nov 95-6
Toxoplasmosis Aug 77-8
DAVIS EP, PARNES JN: Case for success in narcotic drug addiction May 63-5
DE HOFF JB: Vanishing diffuse outpatient department Mar 44-9
DEINHARDT FW: Symposium on viral diseases: hepatitis Apr 59-62

ENGEL RM, SCOTT WW: Hypospadias: experience with a new one-stage repair (Hodgson urethroplasty) June 45-9
ENTWISLE G: See Stewart WL
ERKAN KA, RIMER BA, STINE OC: Juvenile pregnancy role of physiologic maturity Mar 50-2
ESTERLY RW: Alcoholic rehabilitation program in the Prince George's county division of parole and probation Oct 81-4
The drunken driver in the alcoholic rehabilitation program Nov 71-2
FARBER RE: Baltimore's health highlights for 1970 Mar 97-100
Child lead paint poisoning Aug 51
Dr. De Hoff appointed chairman of National Health Records Committee May 81
Health corporations: a new approach for health manpower, cooperation and care Nov 16-17
Interracial marriages in Maryland Jan 85
Mobile dental units planned Feb 85
New clinic in South Baltimore Aug 51
Podiatry clinic in western health district building Apr 85
Progress notes Sep 65
FINE EM: Urban health challenge: survey of physician manpower in metropolitan Baltimore Oct 67-71
FLEISCHER CJ: Ambulation aids Oct 57-61
FRIEDMAN RM: Antiviral agents Apr 70-5
GARBER HJ: Immunization requirements for travelers Jul 130-2
GOLD MI: Respiratory failure: failure or success? Feb 57-8
GONZALES EP: See Walker JH
GORWITZ K, WARTHEN FJ: Maryland faces the 1970s Feb 64-8
GRINDON AJ: Maryland law and blood transfusion June 55-8
GUTTMACHER AF: Changing attitudes and practices concerning abortion: a sociomedical revolution Dec 59-63
HALPERIN HJ: How to diagnose occupational disease Aug 75-6
HALPERIN EJ, COHEN BS: Perceptual-motor dysfunction stumbling block to rehabilitation Jul 139-41
HAMMERMEISTER KE, BELCHER HV: Acute streptococcal pericarditis: report of a case treated with pericardiectomy June 50-4
HELLER RH: Prenatal diagnosis and the prevention of birth defects May 59-62
HENZE WA: People's free medical clinic Jul 58-9
HOOVER EP: Incidents of alcohol and drug related arrests Apr 99-101
HUMPHRIES JO: Atrial septal defect in the adult Mar 89-90
HURLEY CW: Alcoholism: a social study on 200 patients Sep 71-2
JOSEPH JM: Laboratory diagnosis of viral diseases Apr 63-9
KELLOGG DA: Psychiatric syndrome in women evaluated for an unwanted pregnancy Oct 75-8
KELLY DT: Aortic stenosis Dec 73-4
KOTLER MN: See Bodenheimer M
KOTLER MN, TABATZNIK B: Significance of ventricular dysrhythmias in men after myocardial infarction Jul 127-8
LAVINE SA: Field diagnosis of athletic injuries Nov 45-7
LISTER LM: Inpatient alcoholic rehabilitation care May 33-5
MCLAUGHLIN JS, BLACKFORD J: Homograft heart valves Apr 83-4
MANUZAK HF: Puerto Rico: diary of a summer vacation in the winter June 59-64
MIHALAKIS I: Asphyxia from pacifier Mar 53-4
MORGAN WK: Useful symptoms and signs in chest disease Sep 58-60
MULHOLLAND JH: Antibiotic treatment of bacterial endocarditis Feb 89-91
NADEL JA: See Conroe JH
PARISI AF, SCHECHTER E: Systolic intervals for evaluation of left ventricular function Jan 81-3
PARKER JD, et al: Treatment of chronic pulmonary histoplasmosis Apr 93-4
PARNES JN: See Davis EP
PETRUCCI JV: Red cell (packed cell) transfusions: an appeal to reason Jan 61-2
PUSHKIN PH: Overview of fluoridation Jan 73-6
QUEEN D: Attitudes and skills of the nurse in working with the alcoholic and his family June 83-5
READING AJ, BROWN RC: Interdisciplinary alcoholism education for medical and paramedical personnel Mar 85-8
REDDY P, et al: Progressive disseminated histoplasmosis Feb 77-8
RIMER BA: See Erkan KA
ROGUE JL: Mechanism of action of thyroid hormone on the heart Sep 75-7
ROSE TG: Medical education in the 70s: what the student wants Jul 56-7
ROSENHOLTZ MJ: See Sopher IM
ROSENOW EC Jr: Medical knowledge self-assessment program Dec 69-71
SARGEANT J: Executive Director's Newsletter (pp 9-10 in every issue)
Your Medical Faculty at Work:
Jan 77-8
Feb 69
Mar 55
Apr 76
May 74
June 65
Jul 116-18
Oct 36-40
Nov 7
Dec 15
SCHAEFER JF: Medical ethics Mar 42-3
SCHECHTER E: See Parisi AF
SCOTT WW: See Engel RM
SHENKHAM M: How to take a history on an alcoholic Feb 93-5
SJOLUND GC: Women's alcoholic rehabilitation unit utilization in demographic data Dec 42-5
SMOLKIN C, COHEN BS: Vocational evaluation and the stroke patient: a discovery of self Nov 60-2
SOLOMON N: Home health services in the care of the chronically ill Jan 79
Major legislative proposals—1971 Mar 83-4
SOPHER IM, ROSENHOLTZ MJ: A case of isolated papillary muscle infarction with rupture Jan 68-72
SPENCER FC: Bypass grafting for occlusive disease of the coronary arteries May 68-73
STEWART WL, ENTWISLE G: Task performance and task delegation in general practice Aug 67-73
STINE OC: See Erkan KA
TABATZNIK B: See Bodenheimer M
VALL-SPINOSA A, et al: Rifampin in the treatment of drug-resistant TB June 79-80
VASH PD: The new medical student Jul 61-2
WAGLEY PF: What medical students think is wrong with medical education today Jul 55
WALKER SH, GONZALES EP: Cephalexin: effective oral antibiotic for coccal infections Jan 63-5
WARTHEN FJ: See Gorwitz K
WEINSTEIN H: Changing attitudes of medical education and its ramifications upon the student Jul 59-61
WILLIAMS GR: Replantation of amputated extremities: present status Dec 64-8
YOUNG RL, et al: Pulmonary sarcoidosis: a prospective evaluation of glucocorticoid therapy Mar 101-02

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VOLUME 21 FEBRUARY 1972 NUMBER 2


**ARTICLES:**


**EMERGENCY MEDICINE SECTION** ..... **54-76**

**Emergency Departments: Multi-Purpose Medical Centers,** John B. De Hoff, MD ..... **55**

**Equipment: The Good and the Dangerous,** Capt. Harold Evans .... **57**

**Certification: How to do it Effectively,** James D. Carr, MD ..... **60**

**How to Coordinate Emergency Services,** Chief Martin C. McMahon ..... **61**

**Emergency Service Teaching in a Community Hospital,** Joseph I. Berman, MD ..... **63**

**Practicality of a Fully Private Staff,** Emidio A. Bianco, MD ..... **67**

**How to Manage Critical Emotional States 24 Hours a Day—The Staff, Setting, and Coordination Needed to Make This Work;** Robert W. Gibson, MD; Kent E. Robinson, MD; Arthur M. Hildreth, MD ..... **71**


**DEPARTMENTS:**


**Occupational and Environmental Health News—Maryland's Occupational Disease Board,** James Frenkil, MD ..... **16**

**Baltimore City Health Department—Lead Paint Detectors; Sickle Cell Testing** .... **19**

**Maryland State Department of Health and Mental Hygiene—Report on Therapeutic Abortions for Fiscal 1971,** J. King Seegar, Jr., MD ..... **32**

**Your Medical Faculty at Work,** John Sargeant ..... **39**

**Alcoholism Section—The Quarter-Way House: An Innovative Alcoholism Treatment Program,** Mrs. Wendy Maters, RN ..... **40**

**Rehabilitation Medicine—"Bell's" Palsy,** John E. Gessner, MD ..... **82**

**Woman's Auxiliary—Environmental Quiz** ..... **93**

**Library—Thomas Willis; New Accessions** ..... **95**



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ON THE COVER: Appropriate to this Emergency Medicine Issue, the cover photo by Philip Szczepanski pictures the State Police Helicopter on the landing pad atop the seven-story parking garage of the University of Maryland Hospital in Baltimore. The patient, who had practically been scalped in a mini-bike accident in Southern Maryland, was being rushed to University Hospital. Such scenes are fairly common since the heliport was placed in service about two years ago. (The regular series of hospital pictures resumes next month.)

**MISCELLANY:**


Doctors in the News **5**
Doctors Take Note **8**
Medical News Briefs **9**
Director's Newsletter **12**
Annual Meeting News **20, 85**
Emergency Medicine Symposium News **22**
Art & Hobby Exhibit **36**
Book Reviews **46**
Annual Meeting Hotel Reservation Forms **76, 84**
MEDIC **97**
Scientific Exhibits **104**
Classified Advertising **109**
Advertising Index **110**
Semiannual Meeting News **110**



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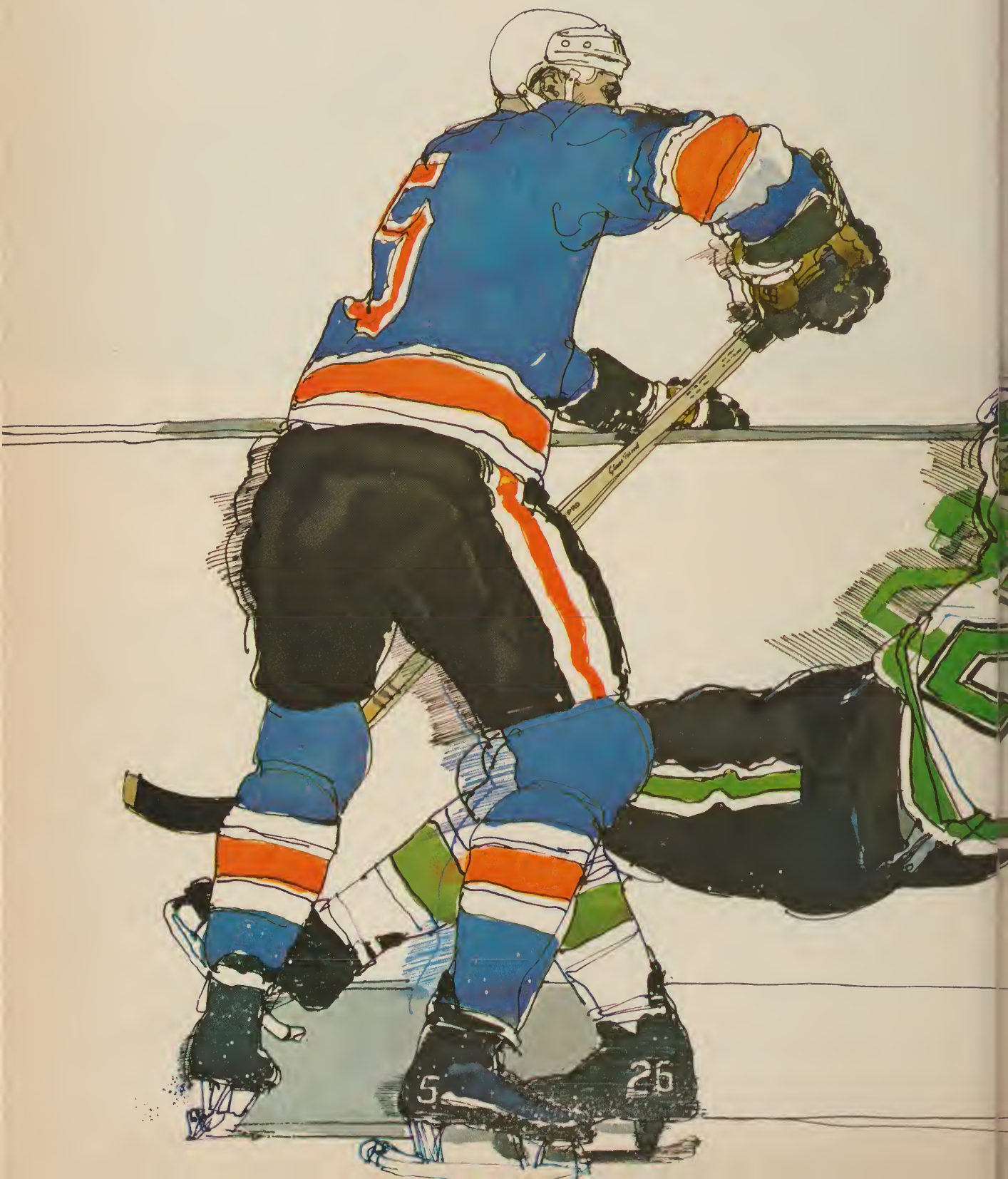
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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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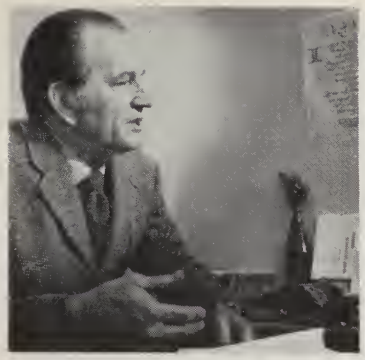
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# Doctors in the News



Dr. Kowalewski

**Edward J. Kowalewski,** MD, a founder of the new specialty of family medicine, has been named professor and head of the Division of Family Practice at the University of Maryland School of Medicine.

A graduate of the George Washington University Medical School, Dr. Kowalewski began a practice in Lancaster County (Pa.) in 1948. In 1953 he formed the first family practice partnership in the East.

As president of the American Academy of General Practice in 1969, Dr. Kowalewski spearheaded the movement to create the specialty of family medicine. This has grown to some 40 departments or divisions of family medicine in the country's medical schools and to about 80 approved residencies.

The objective of these family medicine programs is to educate physicians who can dispense comprehensive health care to families as a unit. In contrast to the traditional general practitioner, the family physician will have specialized training as a medical student, intern, and resident.

There are currently seven residents specializing in family medicine at the medical school in a program that began four years ago. A record 54 freshmen signed up for an elective in family practice this past fall.

When the AAGP became the American Academy of Family Practice in 1970, Dr. Kowalewski was elected as the first president. He has served on presidential commissions and congressional advisory committees and was a delegate to the 1970 World Health Conference.

He received the medical profession's Voice of Medicine award in 1968 and was president of the Fourth World Conference on General Practice held in Chicago last year.

•

**John Payne,** MD, a third year pediatrics resident at the University of Maryland's Baltimore School of Medicine, is currently working in Maryland's mountain counties as the first doctor from the department to participate in a new health project funded by the Appalachian Regional Commission. He received his MPH degree from The Johns Hopkins University.

Residents who choose to rotate through the project will receive from six to eight weeks of clinical field experience in Allegany and Garrett counties working with county health officers, public health nurses, paramedical personnel, and social workers.

The objective of the program is to help county health officers set up a system of comphrensive health services for children, while offering pediatrics residents training in an environment which differs considerably from Baltimore. The residents will also have the opportunity to participate in a group practice.

**William Schuman,** MD, who retired recently as director of medical education of the North Charles General Hospital in Baltimore, was the guest of honor at a retirement dinner by the hospital's medical staff.

Dr. Schuman completed 24 years of service at the hospital, being first chief of obstetrics and gynecology from 1947 to 1954. Later he became director of the postgraduate institute, subsequently became interested in graduate education, and in 1955 was appointed the first director of medical education in any Maryland hospital. At the testimonial dinner, he received a plaque indicating all the positions he had held at the hospital.

•

Four Maryland doctors are among a group of 241 physicians who have met the high standards of the American College of Physicians (ACP) and have been admitted as Members of the 56-year-old international medical specialty society. They are:

**Caridad E. Gonzalez,** MD, Baltimore

**Donald T. Lewers,** MD, Baltimore

**Vincent J. Fiocco, Jr.,** MD, Westminster

**LCDR John B. Closson,** USN, MC, Annapolis

College officers, who will serve until the 53rd Annual Session in Atlantic City, April 16-21, include **R. Carmichael Tilghman,** MD, who serves as secretary general. He also serves as associate professor of medicine at The Johns Hopkins University School of Medicine.

The appointment of **Maureen Henderson,** MD, as chairman of the department of preventive medicine at the University of Maryland School of Medicine has been announced by **John H. Moxley III,** MD, dean of the school. Dr. Henderson is one of only a handful of women in the entire nation who head major departments at medical schools.

A native of Tynemouth, England, Dr. Henderson received her medical education from the University of Durham, England where she was graduated in medicine and in public health. While a fellow in cancer epidemiology at St. Bartholomew's Hospital in London, she attended the London School of Hygiene and Tropical Medicine.

Dr. Henderson joined the medical school faculty (UM) in 1960 and rose from the rank of instructor to that of professor of preventive medicine in 1968. During most of this time she has also held an appointment at The Johns Hopkins School of Hygiene and Public Health. In 1963 she was the second woman to receive the prestigious Markle Scholarship since its establishment in 1948.

She is a member of the American Epidemiological Society, an officer of the International Epidemiological Association, and vice-president of the Association of Teachers of Preventive Medicines.



**Dr. Henderson**

•

The following Montgomery County Medical Society members have been appointed to the AMA committee or council as indicated:

**John J. Curry,** MD, Council on Drugs, reappointed.

**Morris E. Chafetz,** MD, Committee on Alcoholism and Drug Dependence, reappointed.

**Henry C. Huntley,** MD (U. S. Public Health Service), Commission on Emergency Medical Services.

**Robert Van Hoek,** MD (U. S. Public Health Service), Commission on Emergency Medical Services.

Also, **Rev. William Loveless,** Committee on Medicine and Religion.

**William Dvorine,** MD, has been appointed chief dermatologist at Baltimore's Bon Secours Hospital. He received his AB from Western Maryland, his MD from the University of Maryland, and interned at Sinai Hospital.

He established a private practice in dermatology in 1961 upon his return to Baltimore from New York. He also acts as chief for the dermatology section at St. Agnes Hospital and as dermatology consultant at Springfield State Mental Hospital and James Kernan Hospital.

•

The following Baltimore City Medical Society members have been appointed to the AMA committee or council as indicated:

**Albert I. Mendeloff,** MD, Council on Foods and Nutrition, reappointed.

**John C. Harvey,** MD (American Hospital Assn.), Commission on Emergency Medical Services.

**Russell S. Fisher,** MD, Committee on Transfusions and Transplantation, reappointed.

•

A Baltimore surgeon, **Samuel J. Abrams,** MD, has passed his boards and been named a Diplomate by the American Board of Surgeons.





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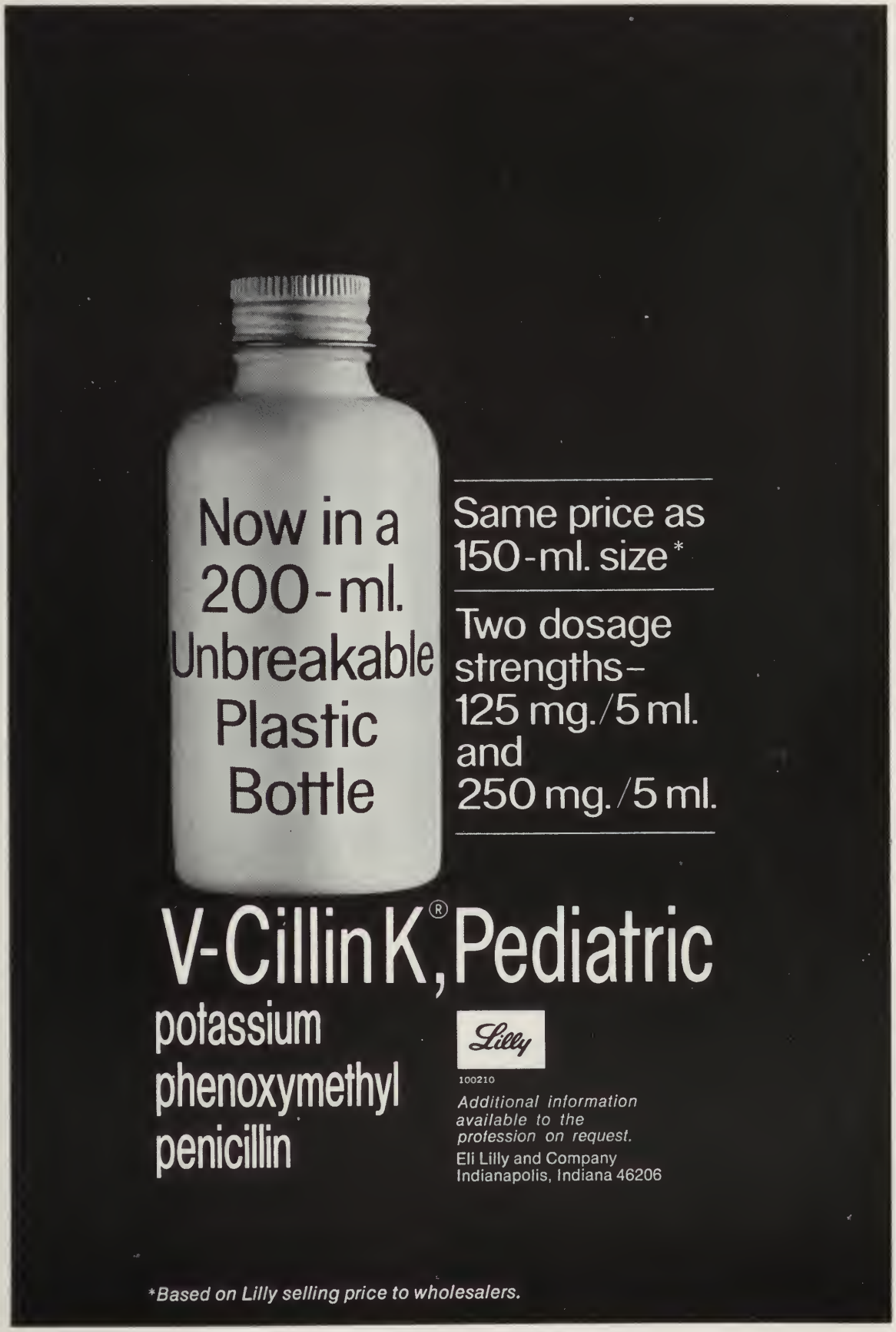
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# Doctors take note...

## Maryland Area Meetings

Mar 1-3 — **National Bureau of Standards.** 13th Scintillation & Semiconductor Counter Symposium. Shoreham Hotel, Washington. Sponsors: Nuclear Science Group of Institute of Electrical & Electronics Engrs, Atomic Energy Comm & NBS. Contact: NBS Office of Technical Information & Publications, Washington DC 20234, phone 921-2691.

Mar 18 — **Central Maryland Heart Assn.** Cardiovascular Disease for Family Physician. South Baltimore Gen Hosp. Contact: Central Md Heart Assn, 415 N Charles St, Baltimore Md 21201.

Mar 27-30 — **Southeastern Surgical Congress.** 40th Annual Assembly. Shoreham Hotel, Washington. Contact: Southeastern Surgical Congress, 340 Boulevard NE, Atlanta Ga 30312.

May 18-21 — **Maryland Academy of Family Physicians.** 24th Annual Meeting. Deep Creek Lake Md. Contact: Daniel Welliver MD, 19 Ridge Rd, Westminster Md 21157 or Mrs Dorothy E Holman, 10 Gerard Ave, Timonium Md 21093.

## American College of Physicians

Feb 23-25 — **Diagnosis & Management of Infectious Diseases.** Univ of Calif, Center for Health Sciences, Los Angeles. Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia Pa 19104.

Mar 6-9 — **Physiological Basis of Clinical Disease.** Univ of Texas Southwestern Med School, Dallas. 20½ hrs credit. Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia Pa 19104.

Mar 7-10 — **Advances in Clinical Endocrinology.** Boston Univ Med Center. 25 hrs credit. Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia Pa 19104.

## American College of Obstetricians & Gynecologists

Mar 2-8 — **Fifth Annual Postgraduate Courses in Gynecological Pathology Cytogenetics & Endocrinology.** Med College of Wisconsin, Milwaukee. Contact: Richard F. Mattingly MD, Dept of Gyn & Ob, Med College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee Wisc 53226.

Mar 8 — **Modern Concepts in Cervical Cancer.** Chicago. Contact: Frontiers of Medicine, Univ of Chicago, 950 E 59th St, Chicago Ill 60637.

Mar 15-17 — **First Annual Congress of Calif Assn for Maternal & Child Health.** Los Angeles. Contact: Calif Assn for Maternal & Child Health, PO Box 965, Los Altos Calif 94022.

Mar 20-31 — **Course in Obn & Gyn** including clinical review of ob & gyn disorders & their med & surgical mgt. Contact: Assoc Dean, Dept of Continuing Educ, Harvard Med School, 25 Shattuck St, Boston Mass 02115.

Mar 29 – Apr 1 — **Anaesthesia Analgesia & Resuscitation in Obstetrics.** Paris. Sponsor: Natl Congress of Anaesthesiology & Resuscitation. Contact: OITT Congres, 62 blvd du Montparnasse, Paris XV France.

### American Academy of Facial Plastic & Reconstructive Surgery

| | | |
|---|---|---|
| Feb<br>Mar | 27<br>3 | **Workshop in Advanced Rhinoplasty.** Dept of Otolaryngology, Baylor Univ College of Med, Houston. Sponsor: AAFP&RS. Contact: Wm K Wright MD, Hermann Professional Bldg, Texas Med Center, Houston Tex 77025. |
| Mar | 13-16 | **Maxillofacial Trauma.** Dept of Otolaryngology & Max Surgery, Univ of Cincinnati Med Center, Cincinnati. Contact: Office of CONMED, College of Med, Univ of Cincinnati, Cincinnati Ohio 45219. |

### Miscellaneous Meetings

| | | |
|---|---|---|
| Feb<br>Mar | 27<br>1 | **American Fertility Society.** Fifth Postgraduate Course Feb 27. 28th Annual Meeting Feb 28 - Mar 1. Contact: Med Director, American Fertility Society, 1801 Ninth Ave South, Birmingham Ala 35205. |
| Mar | 1-4 | **American Academy of Forensic Sciences.** 24th Annual Program. Sheraton-Biltmore Hotel, Atlanta. Contact: Harlan L Kimball, AAFS, PO Box 302, Hartford Conn 06057. |
| Mar | 1-5 | **American College of Cardiology.** 1972 Scientific Session, Conrad Hilton Hotel, Chicago. Contact: Wm D Nelligan, ACC, 9650 Rockville Pike, Bethesda Md 20014. |
| Mar | 13-16 | **HEW Center for Disease Control.** Natl Conf on Current Concepts in Communicable Disease Control. Sheraton-Lincoln Hotel, Houston. Contact: Director State & Community Services Div, Center for Disease Control, Atlanta Ga 30333. |
| Mar | 16-17 | **25th Natl Conf on Rural Health.** St Francis Hotel, San Francisco. Sponsor: AMA Council on Rural Health et al. Contact: AMA Council on Rural Health, 535 N Dearbon St, Chicago Ill 60610. |
| Mar | 22-25 | **National Congress—Quality of Life.** Palmer House, Chicago. Sponsor: AMA et al. Contact: AMA, 535 N Dearborn St, Chicago Ill 60610. |
| Mar | 23-26 | **American Football & Basketball Conf.** Univ of Notre Dame. Sports-related injuries. Contact: Notre Dame Center for Continuing Educ, South Bend Ind. |
| Apr | 10-11 | **Cancer Seminar.** Flamingo Hotel, Las Vegas. Sponsor: American Cancer Society. Contact: Cancer Seminar, 301 S Highland Dr, Las Vegas Nev 89106. |
| May | 6-9 | **Medical Society of New Jersey.** 206th Annual Meeting. Haddon Hall, Atlantic City. Med-Chi mbrs are invited to submit scientific exhibits. Contact: MSNJ, PO Box 904, Trenton N J 08605. |

# MEDICAL NEWS BRIEFS

## HEART VISITS SET

The Heart Association of Maryland reports that three Visiting Scientist Award recipients will visit the Maryland scientific community in February, March, and April.

Norman C. Staub, MD, professor of physiology at the Cardiovascular Research Institute, University of California Medical Center, San Francisco, Calif. 94122, will be here from February 21 through 23. His host will be Solbert Permutt, MD, of The Johns Hopkins School of Hygiene.

From March 27 through 29, J. Willis Hurst, MD, professor and chairman of medicine, Department of Medicine, Emory University School of Medicine, Atlanta, Ga. 30324, will be hosted by Richard S. Ross of The Johns Hopkins University School of Medicine.

The series concludes with an April 13-14 visit by Norman E. Shumway, MD, PhD, professor and chairman, Division of Cardiovascular Surgery, Stanford University School of Medicine, Stanford, Calif. 94305. Dr. Shumway's host will be Joseph McLaughlin, MD, of the University of Maryland School of Medicine.

Information regarding these visits may be obtained through the Heart Office, 415 North Charles St., Baltimore, Md. 21201, phone (301) 685-7074.

## Clinical Center Studies Thyroid Carcinoma

HEW requests the cooperation of physicians in the referral of patients with thyroid carcinoma for a continuing study being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, Bethesda, Md.

Patients are needed with thyroid carcinoma that concentrates I-131 and is not subject to surgical cure. Selected patients will be admitted for evaluation and study, and specific therapy will be initiated if desired. A hospital stay of several weeks should be anticipated.

Upon completion of their studies, patients will be returned to the care of the referring physician. He will receive a summary of the diagnostic findings and suggestions for future care if appropriate.

Physicians interested in having their patients considered for admission to this study may write or telephone Richard Sachson, MD, Clinical Center, Room 8N-262, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-3058.

## LUNG CARCINOMA GETTING HEW STUDY

HEW requests the cooperation of physicians in the referral of patients with carcinoma of the lung for clinical study and treatment by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md.

All previously untreated patients with a tissue or unequivocal cytologic diagnosis of bronchogenic carcinoma, who are unresectable because of local extension only, or who refuse surgery, will be considered. Patients who have had an attempted partial resection, or patients with serious medical complications contraindicating surgery are not acceptable.

Upon completion of treatment, patients will be returned to the care of the referring physician, who will immediately receive a summary of the findings.

Physicians interested in having their patients considered for admission to this study may write or telephone Kent B. Lamoureus, MD, Clinical Center, Room B3B-38, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-5457.

## Day Treatment Center Opened

The Seton Psychiatric Institute, 6400 Wabash Avenue, Baltimore, Md. 21215, announces the opening of its Day Treatment Center for the care of the ambulatory, emotionally disturbed individual.

Their Guide for Professional Agencies leaflet may be secured by writing Marie C. Rigaud, MD, at the above address.

Referrals and inquiries should be directed to Seton's Department of Social Services, phone (301) 764-2200.

## NIH ASSOCIATESHIPS BEING OFFERED

Application forms for Clinical, Research, and Staff Associateships at the National Institutes of Health in Bethesda, Md. are now available. These two-year positions offer unusual oportunities for training and experience in clinical and laboratory investigation for young physicians and dentists in most of the health specialties and basic science disciplines.

Deadline for receipt of applications in March 3. Interview period is May 8 through 26. Successful candidates will be notified on June 12.

Descriptive 1972 catalog and application forms may be obtained from Chief, Clinical and Professional Services, National Institutes of Health, The Clinical Center, Room 1S-229, Bethesda, Md. 20014.

## HEW STUDYING LUPUS NEPHRITIS

The cooperation of physicians is requested in a therapeutic study of lupus nephritis being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, Bethesda, Md. Patients with systemic lupus erythematosus may develop an immune complex nephritis which can be fatal.

Of interest are patients with lupus nephritis who would be willing to enter the clinical center for a three-month period. If certain clinical and laboratory criteria are fulfilled, these patients would be admitted for a therapeutic study involving cyclophosphamide or azathioprine. Additional studies include attempts to define the relationship of viral infection to the disease. Patients already on corticosteroids will be considered; however, those currently receiving cytotoxic agents are excluded.

Physicians interested in referring patients for this study may write or telephone Alfred D. Steinberg, MD, or John L. Decker, MD, Clinical Center, Room 9N-218, National Institutes of Health, Bethesda, Md. 20014, phone 301-496-1961.



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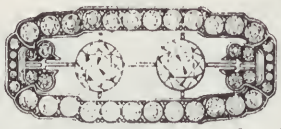
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# executive director's newsletter

February 1972

**BNDD NUMBERS**

Physicians are again reminded that it is not necessary to use the State Drug Identification Number on their Rx blanks. All that is necessary is that the physician identify himself by the use of his Federal Bureau of Narcotics and Dangerous Drug Number, which will remain the same as long as it is in force.

**BLUE CROSS BENEFITS**

Alcoholism is a treatable disease and is fully covered under the terms of both Blue Cross and Blue Shield contracts. The use of this terminology for an admitting and discharge diagnosis will not preclude payment of benefits under Blue Cross and Blue Shield.

**ALCOHOLISM RECORDS AVAILABLE**

A series of five records dealing with treatment of alcoholism is available to those physicians who would like to hear them. Full information can be obtained through the Faculty office.

**PROFESSIONAL LIABILITY REPORTS**

Arrangements have been completed for copies of Professional Liability claims to be sent to the Faculty when filed with the St. Paul Companies, Faculty-endorsed carrier. The physician must certify on the claim form that he authorizes release of this date to the Faculty. All physicians are urged to complete this section of the report form.

**ORIENT ADVENTURE**

Arrangements have been made for a 14-day Orient Adventure to take place from July 23 through August 6, 1972.

The all-inclusive price is $898, which includes transportation (100 lbs. baggage allowance), hotels, breakfast and dinner each day, and transfers and tips. Reservations should be made through the Faculty office and accompanied by a deposit of $100 per person. Deposits are refundable up to 60 days before departure. Checks should be made payable to the Medical and Chirurgical Faculty.

ORIENT ADVENTURE (cont'd)

Arrangements are underway to provide scientific programs for the 7 days in Tokyo and the 7 days in Hong Kong. These will be held in the early morning.

USE OF UNLICENSED PHYSICIANS

Mailed to all physicians holding Maryland licenses, as well as to hospital administrators, by the Board of Medical Examiners, is a letter bringing to their attention the only circumstances under which such unlicensed physicians may be used.

Physicians are urged to evaluate their current practices in connection with unlicensed medical doctors to ascertain they are within the current statutes in this regard.

LOCAL AMA APPOINTMENTS

The AMA Board of Trustees has named the following physicians from Maryland to the Council or Committee shown:

John J. Curry, MD, Silver Spring, to the Council on Drugs; Albert I. Mendeloff, MD, Baltimore to the Council on Foods and Nutrition; Morris E. Chafetz, MD, Rockville, to the Committee on Alcoholism and Drug Dependence; John C. Harvey, MD, Baltimore, Commission on Emergency Medical Services, representing the American Hospital Association, and Henry C. Huntley and Robert Van Hoek, representing the US Public Health Service; Russell S. Fisher, MD, Baltimore, Committee on Transfusion and Transplantation. The Rev. William Loveless, Takoma Park, was appointed to the Committee on Medicine and Religion.

LEGISLATIVE ACTION

The Faculty will support legislation dealing with the repeal of current laws requiring vaccination against smallpox of children during their first year as well as on entering school. This will be replaced by a statute permitting the Department of Health and Mental Hygiene, in cooperation with the Faculty, to designate immunizations required of people "at risk."

John Sargeant

Executive Director

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**occupational and environmental health news**

# Maryland's Occupational Disease Board

**JAMES FRENKIL, MD**
**Director, Central Medical Centre**
**Chairman, Occupational Disease Board, State of Maryland**

An attractive young woman worked in a most unglamorous job in a large, noisy butcher shop. She was not a meat cutter, but actually was an order taker as she was required to answer the telephone and call out the orders to the various butchers, who were expected to fill them. She was seated on an elevated platform in the middle of the shop in a booth-like arrangement which contained several telephones. It was necessary for her to call out the orders in a loud voice to about one half dozen butchers surrounding the booth and located about ten feet away from it. This occupation required constant use of her voice above the normal conversational tones for at least six or seven hours per day. This young lady had a fine melodious voice when she first took the position; however, after several years, she began developing a rasping, harsh hoarseness in her speech in calling out the orders. She sounded like a man when she answered the phone. The loss of that pleasant sounding voice caused her to lose her job.

Concerned with this chronic hoarseness and upset about being fired because of it, she sought the opinion of a family physician, who referred her to a nose and throat specialist. The examination revealed that she had "singer's nodes" on her vocal cords, and she was advised to have them surgically removed. When questioned by this physician as to the onset, she described her work at the butcher shop and he, in turn, indicated that, in his opinion, her occupation caused the trouble. She subsequently had the surgery performed and improved considerably afterwards. Nevertheless, because of her physician's opinion, she felt compensation was due her and, under the advice of an attorney, she filed a claim against the employer.

This claim was contested by her employer and, therefore, was assigned to the Occupational Disease Board for a hearing and ultimate decision. The facts were presented as described in the testimony by the claimant and also by her physician. They were not substantially refuted by the employer, although an effort was made by him to show that such a condition was "not peculiar nor characteristic" of an order taker in a butcher shop. The Board ruled in favor of the lady. What would you do?

In making its decision, the Board considered the following facts for not making an award to the claimant:

1) that her job was relatively commonplace and not a hazardous one;
2) that very few people develop singer's nodes as an occupational disease nor were they aware of any evidence of such a case on record; and
3) that the application of the criterion that an occupational disease should be "peculiar and characteristic" to one's occupation did not fit.

Based on these facts, we could have decided against the claimant, but we went a bit further and took into consideration the following:

1) that the young lady's voice did not change until after she had been working for some time;
2) that this voice problem did not at any time pre-exist her employment with the butcher shop;

3) that even though her work was of a simple nature and could not readily be considered an occupational hazard, the circumstances of the noisy shop required her to use her voice at a much louder pitch than normal and use it over long periods of time;
4) the fact that this employee may have had some increased sensitivity above the average, as one might be more sensitive to certain allergens;
5) when there is sufficient doubt in adjudicating a claim, the rule of the Commission is to resolve the doubt in favor of the claimant; and finally
6) the unnecessary need to adhere to scheduled diseases due to the changes in the law, eliminating specific schedules of recognized occupational diseases.

The purpose of presenting this case history and the reasoning for the Board's decision is mainly to point out that

1) all claims set before the Occupational Disease Board are not exotic nor unusual problems such as ethyl-methyl-ketone poisoning, anthrax, silicosis, lead poisoning, and other specific disorders known to be a direct sequelae of one's work exposure; also
2) to draw attention to a major change that has occurred to the Occupational Disease Act passed by the Maryland legislature in 1939; and
3) to show that meticulous care is necessary in rendering an opinion and much depends upon the judgment of the members of the Board.

Formerly in Maryland, prior to June 1951, the diseases considered to be occupational were listed and there were 34 of such scheduled. They consisted of specific illnesses, such as silicosis and asbestosis, lead and mercury, arsenic and other metallic dust poison, carbon monoxide, sulfur dioxide, hydrogen sulfide, and other gaseous intoxications, etc.

When a disease of a compensable nature occurred that was not included in this list, there could be no allowance and it was ruled noncompensable. The list omitted many conditions that had been more or less proven to be direct results of an occupational exposure; therefore, to correct this situation, a new amendment was passed by the Maryland legislature in 1951 which eliminated the old schedule and proposed that "all diseases arising out of, and in the course of, employment" were to be considered.

The intention of this paper is not to go into the details of the Maryland Occupational Disease Act of 1939; however, this act was carefully thought out and covered a wide range of material, particularly from a study of the laws of other states. I would like to point out, however, that a major part of the act was to provide ". . . for the creation of a medical board of three physicians. Two shall be experienced in the diagnosis, treatment and care of industrial disease and one shall be an expert roentgenologist. All were required to have practiced their respective specialties for five years and must be in 'good' professional standing. The names shall be chosen from separate lists of not less than three persons to be submitted to the Governor independently by the deans of Johns Hopkins and University of Maryland medical schools and the Council of the Medical and Chirurgical Faculty of the State of Maryland. The term of the members is to be six years and the original appointments are to be made so that a term will expire every two years. The chairman is to be designated by the Governor.

"Generally the powers of the Medical Board involve the right to formulate rules to govern their procedures, to investigate working conditions, to order and conduct autopsies, to have laboratory work carried out and to conduct hearings and render decisions on medical questions."

The Board is a division of the Workmen's Compensation Commission and the decisions of the Board are subject to review of the Commission and subject to appeal to the higher courts.

It is in reality a quasi-judicial group that for the most part has hearings in a semiformal fashion with the fundamental purpose of obtaining all the facts possible in order for it to render fair decisions. Generally all members of the Board sit at the hearings which are held mainly in Baltimore City; but on a number of occasions throughout the year, it is necessary to conduct hearings in other parts of the state.

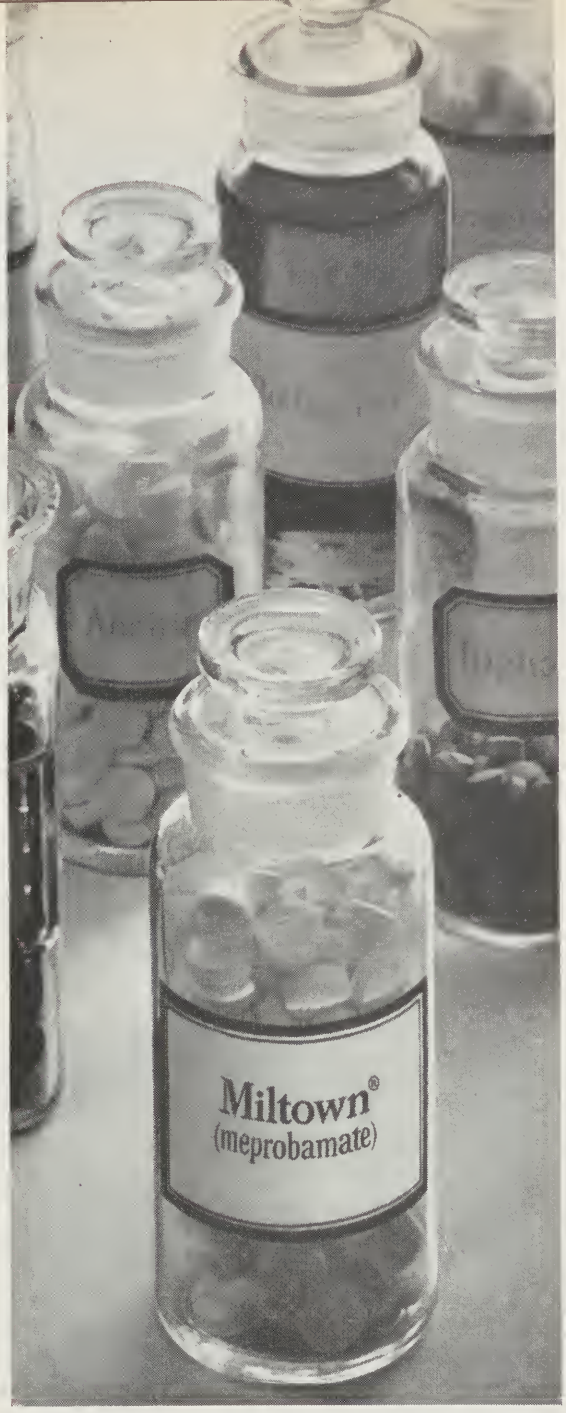
My desire in this report is to, in a brief way, acquaint the Maryland physicians with some basic information about the Occupational Disease Board of this state, but I would like to include a few additional words that I feel are pertinent at this time.

Occupational medicine is still in a transitional stage, both as to legislation and to administration. Because of the modern manufacturing processes, new hazards are constantly being created and old hazards are causing new disabilities previously largely overlooked or at best only vaguely contemplated. The employee has little opportunity to protect himself from occupa-

tional diseases; only the employer is able to provide safeguards and exercise preventive measures. Occupational disease is often more devastating in result than is accidental injury, and it is insidious in the sense that the final results come from exposure over a period of time and thus may induce feelings of false security or failure to anticipate results.

I would like to touch briefly on the testimony that the Board desires when they are hearing cases. All medical testimony should follow certain general and common sense principles. Today, because of the frequency of, and ever increasing, medicolegal problems, the very license to practice medicine makes it tantamount for all of us to be willing and able to testify in the courts. Excluding the many other reasons that physicians are needed in the court, one who accepts or deals with compensation cases must, from the onset, realize that these are often medicolegal problems and that he might be called upon at any time to substantiate his opinion under oath before a referee, judge, or other tribunal. Thus, firstly we (physicians) should be willing to wholeheartedly cooperate with the courts and sincerely accept that there is a need for our services to aid and settle disputes over medical matters. I don't think it is fair for physicians to refuse to handle certain cases, the nature of which might make necessary for them to testify in court.

Secondly, the physician should have full knowledge of the case and report his findings accurately and, I might add, honestly, for too often we are categorized as "claimants' physicians" and, conversely, "company physicians."


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**Baltimore City health department**

## New Lead in Paint Detectors

The City Health Department's Bureau of Industrial Hygiene has received two newly developed lightweight, portable X-ray lead analyzers which should greatly speed the detection of lead paint in Baltimore homes. Mr. Elkins W. Dahle, Jr., director of the bureau, reports that the machines, which cost $4,750 each, can determine during a sanitarian's inspection if the paint in a home has dangerous amounts of lead in it. Although trained sanitarians will begin using the new analyzers immediately, the usual method of scraping paint samples for later laboratory analysis will be continued for awhile in studies correlating the machines' readings with laboratory determinations.

If sanitarians find there is more than one percent of lead in paint in a home, they notify the owner to remove all paint on chewing surfaces within ten days which a child can reach and all peeling paint elsewhere in the home. Although an effective law was passed in 1958 that virtually stopped all interior painting with paint containing lead, many houses built before that date still have lead paint in them. Such houses represent a constant danger to young teething age children who eat peeling paint or chew on painted surfaces.

By purchasing the new digital lead analyzers, Baltimore continues in the forefront of the nation's attack on the child lead paint danger. The investment should soon pay dividends in a speedier identification of dangerous dwellings, in paint removal, and in protecting our young.

Physicians are urged to be alert to the lead paint danger and to suspect lead if a child has vague symptoms of physical or mental distress. Additional information may be obtained by calling 752-2000, extension 843.

## Sickle Cell Testing at Baltimore Maternity Center

A screening program for sickle cell anemia has been started at the Baltimore Maternity Center, 211 West Lombard Street, according to George H. Davis, MD, director of the 501 Project and A.S. Zachary, MD, director of Family Planning Project 722.

The screening is available for women coming in for pregnancy registration at the maternity center and for patients in the family planning clinics. If a woman is found to have either sickle cell trait or true sickle cell anemia, the father of the child will also be tested. Of those tested so far in city clinics, 8.5 percent were found to have the trait. National figures show that from seven to ten percent of black Americans have the condition. Genetic counseling will be provided for those patients needing it.

The City Health Department is also planning to increase sickle cell screening within other facilities, and soon the tests will be done on children in child health clinics and those attending the comprehensive children and youth clinics.

Sickle cell anemia is an inherited red blood cell defect that affects black people, people of Caribbean and Latin American origin, and those from the Mediterranean area. Persons who have sickle cell trait have no symptoms under normal circumstances. They are not sick, but if they marry someone with the trait, they can pass the condition on to some of their children with the statistical probability that one in four may be born with true sickle cell anemia.

By screening for sickle cell anemia, the City Health Department's maternity and family planning projects can inform people whether they carry a trait or true sickle cell anemia and how it might affect their children. It is particularly important in helping couples in planning their families.

# MORE ABOUT THE 1972 ANNUAL MEETING of the MEDICAL AND CHIRURGICAL FACULTY MAY 3, 4, 5, 1972 BALTIMORE CIVIC CENTER

On Wednesday afternoon, May 3, **Otto C. Page, MD,** President of the American Society of Internal Medicine and Associate Professor of Medicine at the University of Oregon Medical School, will speak at the plenary session on **PEER REVIEW — PROBLEMS AND POTENTIALS.** This discussion is vitally important to **ALL** physicians.

All day Thursday and Friday, many specialty societies will have concurrent sessions:

**CURRENT ASPECTS OF CARDIAC SURGERY**
Moderator: **Joseph S. McLaughlin, MD,** Head of Division of Thoracic and Cardiovascular Surgery, University of Maryland School of Medicine

**VALVULAR HEART SURGERY — Safuh Attar, MD,** Professor of Thoracic Surgery, University of Maryland School of Medicine

**CONGENITAL HEART DISEASE — Stephen Z. Turney, MD,** Assistant Professor, Division of Thoracic and Cardiovascular Surgery, University of Maryland School of Medicine

**TREATMENT OF ACUTE CARDIOGENIC SHOCK WITH SAPHENOUS VEIN BYPASS — W. Gerald Austen, MD,** Professor of Surgery, Harvard Medical School

**MEDICAL LEGAL COMPLICATIONS OF INDUSTRIAL MEDICINE — Charles J. Frankel, MD,** Associate Professor of Orthopedics, University of Virginia Medical School

**CYTOTOXIC AGENTS IN THE TREATMENT OF RHEUMATIC DISEASE — John L. Decker, MD,** Chief, Arthritis and Rheumatism Branch, National Institute of Arthritis and Metabolic Diseases

**BATTERED CHILDREN: NEW CONCEPTS, NEW ACTIONS — Brandt F. Steele, MD,** University of Colorado Medical Center

**THREE DELIVERIES THAT CHANGED THE HISTORY OF THE WORLD — Louis M. Hellman, MD,** Deputy Assistant Secretary, Population Affairs, Department of Health, Education and Welfare

**PRESCRIPTION DRUGS, PSYCHOPHARMACOLOGIC PATTERNS IN PRACTICE — Jerome Levine, MD,** National Institute of Mental Health

**RAPID RECOGNITION OF SUICIDES AND MODERN MANAGEMENT METHODS — Joy Ruth Joffe, MD,** Phipps Clinic, The Johns Hopkins University School of Medicine

**CLINICAL PHARMACY: A NEW PROFESSION**

**CHANGING ROLES FOR PHARMACOLOGISTS — William J. Kinnard, Jr., PhD,** Dean and Professor of Pharmacology and Toxicology, University of Maryland School of Pharmacy

**HOSPITAL CLINICAL PHARMACISTS, PRACTICAL CONSULTANTS FOR MDs — Robert A. Kerr, PharmD,** Instructor in Pharmacy, University of Maryland School of Pharmacy

**WHAT YOU MUST KNOW ABOUT DRUG INTERACTIONS — David A. Blake, PhD,** Associate Professor and Chairman, Department of Pharmacology and Toxicology, University of Maryland School of Pharmacy

**DRUG INFORMATION SERVICES, OR WHAT YOU WANT TO KNOW BUT ARE AFRAID TO ASK — Peter P. Lamy, PhD,** Associate Professor and Director, Institutional Pharmacy Programs, University of Maryland School of Pharmacy, and Winifred Sewell, BSLS, Adjunct Assistant Professor of Pharmacy, University of Maryland School of Pharmacy

**BIOAVAILABILITY AND DRUG PRODUCT DESIGN: IT AFFECTS YOUR PATIENT, YOUR THERAPY! Ralph F. Shangraw, PhD,** Professor and Chairman, Department of Pharmacy, University of Maryland School of Pharmacy

**CLINICAL MANAGEMENT OF SYNDROMES ASSOCIATED WITH ABNORMAL CELLULAR IMMUNE REACTIONS — H. Sherwood Lawrence, MD,** Professor and Head, Infectious Disease and Immunology Division, New York University Medical Center

**DIABETIC RETINOPATHY: A FRESH CONCEPTUALIZATION — Arnall Patz, MD,** The Wilmer Ophthalmalogical Institute, The Johns Hopkins University School of Medicine

**THE DOCTOR'S LEGAL DILEMMA: PRESENT AND FUTURE** — a medicolegal symposium

Programs will also be offered by the **Md. Dermatologic Society,** the **Trauma-Committee of the American College of Surgeons, Maryland Society of Rehabilitation Medicine, Maryland-District of Columbia Society of Anesthesiologists,** the **Heart Association of Maryland,** and the **Maryland Diabetes Association.**

* * * * * * *

On Thursday, May 4, the annual **ROUND TABLE LUNCHEON** will be held at the Holiday Inn-Downtown, and that evening the annual **PRESIDENTIAL RECEPTION AND BANQUET** will be at the Blue Crest North. On Wednesday evening there will be a **HOSPITALITY NIGHT** at the Hilton Hotel to which all members of the Faculty will be invited. Many **SCIENTIFIC and TECHNICAL EXHIBITS** will be on display at the Civic Center, as well as the very popular **ART AND HOBBY EXHIBITS.**

BE SURE TO MARK THESE DATES ON YOUR CALENDAR **NOW**

MAY 3, 4, 5, 1972

John B. De Hoff, MD, Chairman
Committee on Program and Arrangements

EMERGENCY MEDICAL SERVICES
SECOND ANNUAL SYMPOSIUM

# "THE UNCONSCIOUS PATIENT IN THE EMERGENCY ROOM"

WEDNESDAY, MARCH 22, 1972
at the
Sinai Hospital, Baltimore, Maryland

Sponsored by the **MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND**

| | |
|---|---|
| 8:00-9:00 am | REGISTRATION |
| 9:00 | FILM — **"EMERGENCY CARE OF ACUTE DRUG OVERDOSAGE"** |
| 9:45 | **HOW I WOULD MANAGE THE UNCONSCIOUS CHILD**<br>**Robert S. Mosser, MD**<br>Assistant Professor of Pediatrics, Neurology<br>University of Maryland School of Medicine |
| 10:30 | INTERMISSION — **VISIT EXHIBITS** |
| 10:50 | **THE UNCONSCIOUS CHILD AS THE NEUROSURGEON SEES HIM**<br>**R.M.N. Crosby, MD**<br>Associate Professor of Neurological Surgery (Pediatric)<br>University of Maryland School of Medicine |
| 11:45 | LUNCH |
| 1:00 | **UNCONSCIOUS? IT COULD BE ANYTHING!**<br>**Theodore Goldberg, MD**<br>Director of Medicine and Chief of Cardiology<br>Pascak Valley Hospital<br>Westwood, New Jersey |
| 1:45 | INTERMISSION — **VISIT EXHIBITS** |
| 2:00 | **TRAUMA AFFECTS THE ENTIRE PATIENT**<br>**James E. Dunn, II, MD**<br>Assistant Professor of Neurosurgery and<br>Clinical Director, Shock-Trauma Unit<br>University of Maryland School of Medicine |
| 2:45 | **PANEL — WITH ALL SPEAKERS PARTICIPATING** |

ARRANGEMENTS HAVE BEEN MADE AT THE LEVINDALE AND SINAI PARKING LOTS. PRESENT PARKING CHECK AT THE REGISTRATION DESK.

Ad Hoc Planning Committee for Symposium
George H. Greenstein, MD, Chairman

DETACH AND MAIL THE FOLLOWING REGISTRATION FORM **TODAY** TO:

SYMPOSIUM ON THE UNCONSCIOUS PATIENT IN THE EMERGENCY ROOM
Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201

**REGISTRATION INCLUDING LUNCH $5.00**

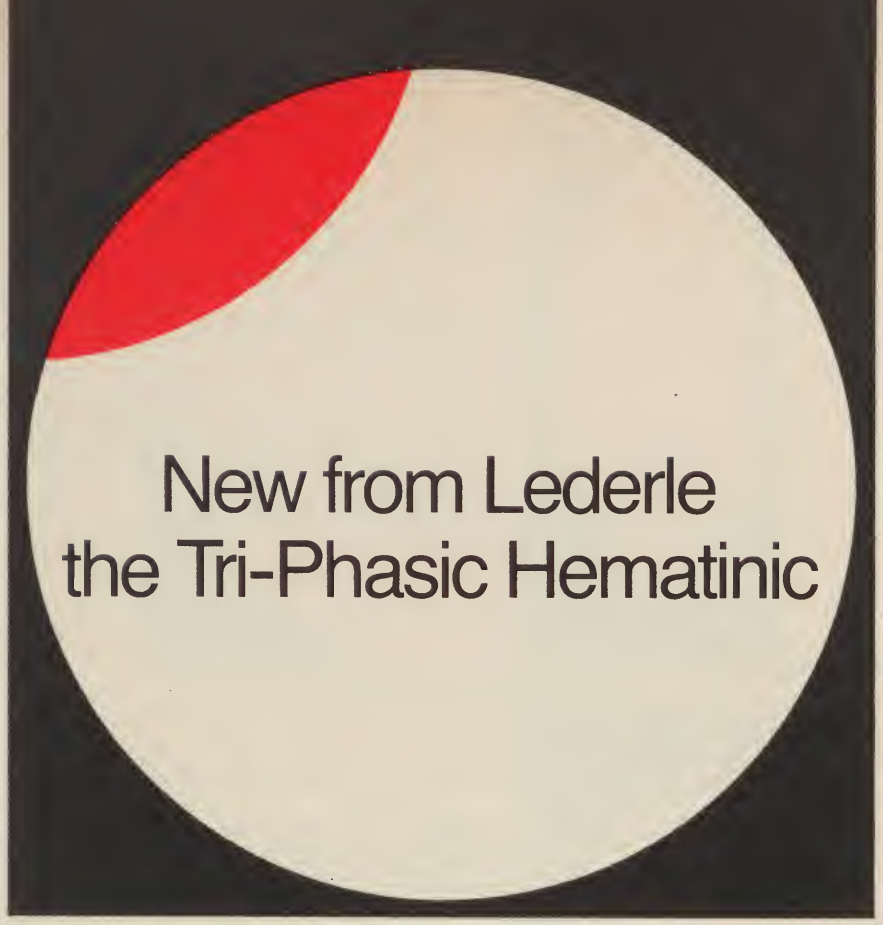
I plan to attend the symposium on Wednesday, March 22, 1972 at Sinai Hospital, and enclosed is a check* for $..... for registration of #..... persons.

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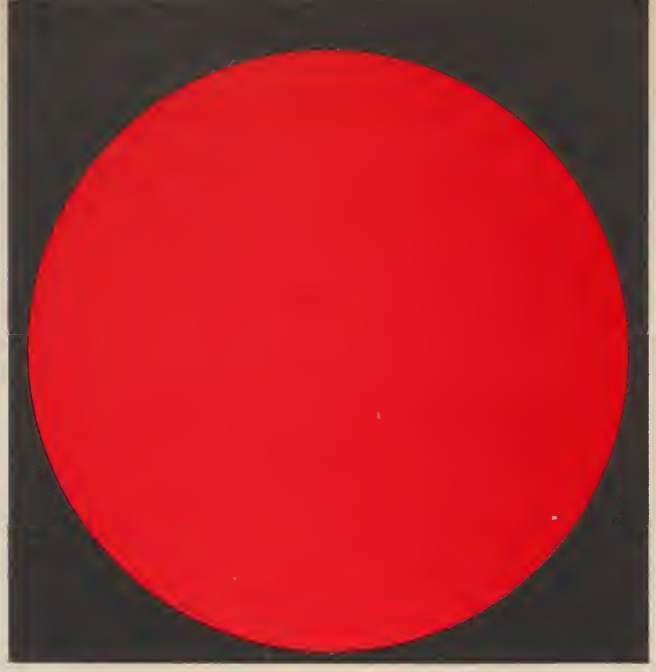
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# PHASE 3
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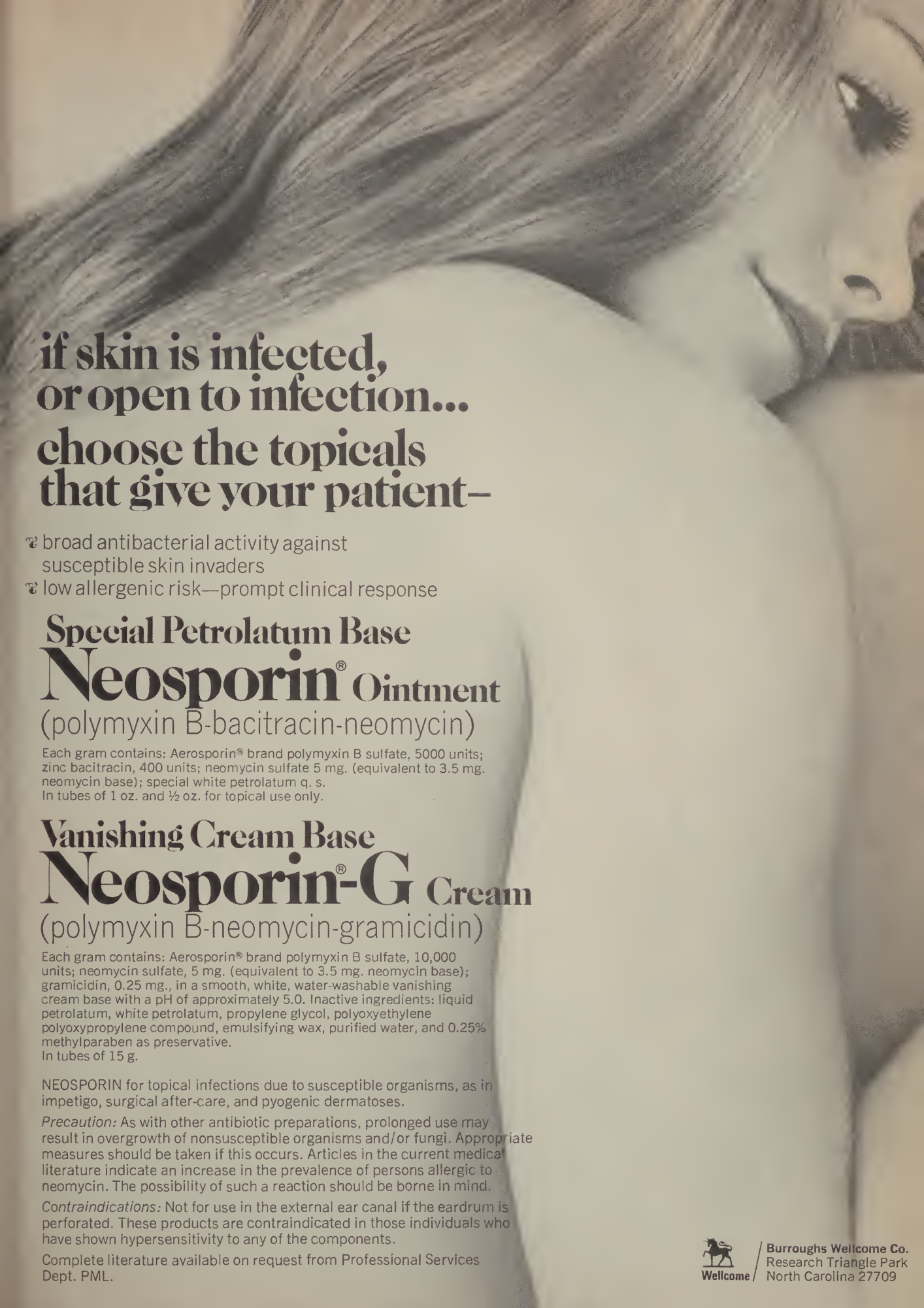
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NEIL SOLOMON, MD, PhD, SECRETARY

**Maryland State department of health and mental hygiene**

# Report on Therapeutic Abortions for Fiscal 1971

**J. KING B. E. SEEGAR, JR., MD**
**Chief, Maternity and Family Planning Section**
**Division of Maternal and Child Health**
**Preventive Medicine Administration**

We have completed the first year of reporting under the Therapeutic Abortion Surveillance System, and we are gratified with the cooperation of all physicians throughout the state in this undertaking. This report summarizes the entire year's progress, and is intended to be a supplement to the four quarterly reports previously issued.

Maryland's 40 nonfederal general hospitals with obstetrical services reported a total of 7,757 therapeutic abortions performed between July 1, 1970 and June 30, 1971. (This is larger than the total reported in the four quarters because of late reporting of 500 abortions.) This represents a significant increase over the 5,530 abortions reported in Fiscal Year 1970 and the 2,134 abortions reported in Fiscal Year 1969, the first year after change in the law.

The same hospitals reported a total of 54,596 live births during the Fiscal Year 1971, so the abortion to live birth ratio for Maryland hospitals was 142 abortions per 1,000 live births.

This year, for the first time, significant numbers of Maryland women were reported to have obtained therapeutic abortions in other states. The New York City Health Department, for example, reported that 878 Maryland women obtained abortions in New York City hospitals during the year. In addition, regulations governing abortions in the District of Columbia are quite liberal, making outpatient abortions both inexpensive and readily available. Therefore, we understand that a large number of Maryland women are aborted in Washington, especially from the metropolitan areas of Montgomery and Prince George's Counties.

The total number of abortions performed on Maryland women may thus be conservatively estimated at 10,000 for the year. The number of deliveries on Maryland women, including those occurring out of state, was probably near 69,000 (the total for calendar year 1970), and thus the ratio of Maryland resident abortions to Maryland resident live births would be approximately 145. This represents a 50% increase over last year, and suggests that utilization of abortion by Maryland women will continue to increase for some time.

Characteristics of the 7,757 women obtaining abortions in Maryland hospitals are presented in Tables 1-A and 1-B. Half of the women were under 22 years of age, half were unmarried, and nearly half reported no living children. All but a few were Maryland residents and nearly all obtained the abortion for reasons of mental health. Over 62% of the women had the abortion prior to 12 weeks of gestation, and over 60% of the abortions were done by suction or surgical curettage.

This year, 38% of the abortions were performed on service patients, an increase over the figure for past years (Figure 1). Since only 31% of the deliveries in the 40 hospitals were to service patients, it appears that service patients are at least receiving a proportionate number of abortions. Blacks also accounted for 37% of the abortions, while contributing only 23% of the births last year. These findings suggest that demand for

**Table 1-A: Therapeutic Abortions — Maryland Hospitals July 1, 1970 - June 30, 1971, Fiscal Year Totals**

| Age | Number | Percentage |
|---|---|---|
| <15 | 203 | 2.62 |
| 15-17 | 1065 | 13.73 |
| 18-19 | 1118 | 14.41 |
| 20-24 | 2383 | 30.72 |
| 25-29 | 1331 | 17.16 |
| 30-34 | 879 | 11.33 |
| 35-39 | 550 | 7.09 |
| 40+ | 228 | 2.94 |
| **Total** | **7757** | **100.00** |
| **Race** | | |
| White | 4785 | 61.68 |
| Negro | 2852 | 36.77 |
| Other | 66 | .85 |
| Unknown | 54 | .70 |
| **Total** | **7757** | **100.00** |
| **Marital Status** | | |
| Never Married | 3876 | 49.97 |
| Married | 2494 | 32.15 |
| Separated | 885 | 11.41 |
| Divorced | 394 | 5.08 |
| Widowed | 77 | .99 |
| Unknown | 31 | .40 |
| **Total** | **7757** | **100.00** |
| **Patient Status** | | |
| Private | 4401 | 56.74 |
| Service | 2992 | 38.57 |
| Unknown | 364 | 4.69 |
| **Total** | **7757** | **100.00** |
| **Residence** | | |
| Baltimore City | 3425 | 44.15 |
| Maryland Counties | 4127 | 53.20 |
| Out-of-State | 190 | 2.45 |
| Maryland, unknown | 9 | .20 |
| **Total** | **7757** | **100.00** |

and utilization of abortion services are considerably higher among the poor and among blacks than has been believed previously.

During the four quarters of Fiscal Year 1971, the proportion of abortions done before 12 weeks increased from 56.8% of the total in the first quarter to 65% of the total in the fourth quarter (Figure 2). Since earlier abortions are safer, this represents a desirable trend. It should be possible next year to reach the 70% under-12-weeks figure that has been reported from other areas, such as New York and Oregon.

**Table 1-B**

| Fetal Age, Weeks | Number | Percentage |
|---|---|---|
| <9 | 1535 | 19.79 |
| 9-12 | 3302 | 42.57 |
| 13-16 | 1253 | 16.15 |
| 17-20 | 1565 | 20.18 |
| 21+ | 102 | 1.31 |
| **Total** | **7757** | **100.00** |
| **Number of Living Children** | | |
| 0 | 3662 | 47.21 |
| 1 | 1181 | 15.22 |
| 2 | 1217 | 15.69 |
| 3 | 836 | 10.78 |
| 4 | 445 | 5.74 |
| 5+ | 416 | 5.36 |
| **Total** | **7757** | **100.00** |
| **Religion** | | |
| Protestant | 3725 | 48.02 |
| Catholic | 1346 | 17.35 |
| Jewish | 230 | 2.97 |
| Other | 519 | 6.69 |
| None | 225 | 2.90 |
| Unknown | 1712 | 22.07 |
| **Total** | **7757** | **100.00** |
| **Indication for Abortion** | | |
| Physical Health | 166 | 2.14 |
| Mental Health | 7463 | 96.21 |
| Rape | 18 | .23 |
| Congenital Defects | 37 | .48 |
| Other | 73 | .94 |
| **Total** | **7757** | **100.00** |
| **Method of Abortion** | | |
| Surgical D&C | 730 | 9.41 |
| Suction D&C | 3934 | 50.72 |
| Hysterotomy | 355 | 4.58 |
| Hysterectomy | 302 | 3.89 |
| Saline | 2376 | 30.63 |
| Other | 60 | .77 |
| **Total** | **7757** | **100.00** |
| **Complication** | | |
| None | 6710 | 86.50 |
| Died | 0 | .00 |
| Fever | 83 | 1.07 |
| Transfusion | 20 | .26 |
| Other | 164 | 2.11 |
| Unknown | 780 | 10.06 |
| **Total** | **7757** | **100.00** |

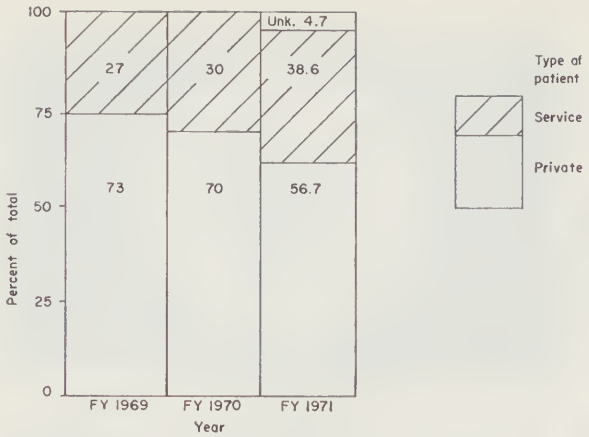



Figure 1: Abortions on private and service patients, Maryland hospitals, FY 1969-1971.

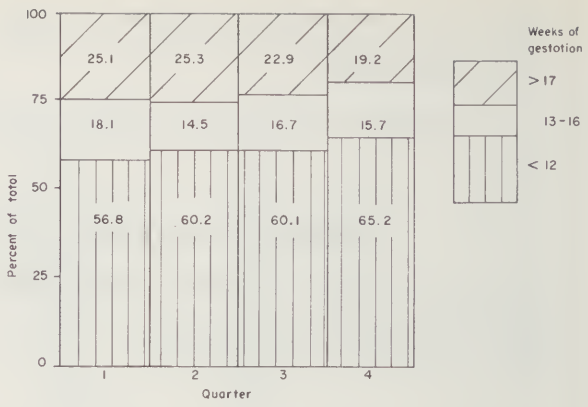



Figure 2: Abortions by length of gestation, Maryland hospitals, FY 1971.

## TABLE 2

### Abortions, Births, and Abortion/Birth Ratio for Maryland Residents by Region, 1970-1971.

| Region and Political Subdivision | Reported Therapeutic Abortions 7/1/70-6/30/71 | Live Births 1/1/70-12/31/70 | Abortions Per 1000 Births |
|---|---|---|---|
| Maryland State | 7,567 | 69,336 | 109.1 |
| Northwest Area | 259 | 5,006 | 51.7 |
| Garrett | 9 | 382 | 23.6 |
| Allegany | 81 | 1,342 | 60.4 |
| Washington | 75 | 1,743 | 43.0 |
| Frederick | 94 | 1,539 | 61.1 |
| Baltimore Metro Area | 6,134 | 34,763 | 176.4 |
| Baltimore City | 3,425 | 16,068 | 213.2 |
| Baltimore County | 1,666 | 9,166 | 181.8 |
| Ann Arundel | 591 | 5,111 | 115.6 |
| Carroll | 114 | 1,155 | 98.7 |
| Howard | 144 | 1,022 | 140.9 |
| Harford | 194 | 2,241 | 86.6 |
| National Capitol Area | 716 | 22,524 | 31.8 |
| Montgomery | 332 | 8,187 | 40.5 |
| Prince Georges | 384 | 14,337 | 26.8 |
| Southern Area | 107 | 2,747 | 38.9 |
| Calvert | 32 | 437 | 73.2 |
| Charles | 31 | 1,068 | 29.0 |
| St. Marys | 44 | 1,242 | 35.4 |
| Eastern Shore Area | 336 | 4,296 | 78.2 |
| Cecil | 56 | 1,086 | 51.6 |
| Kent | 32 | 260 | 123.1 |
| Queen Annes | 21 | 265 | 79.2 |
| Caroline | 21 | 332 | 63.2 |
| Talbot | 46 | 344 | 133.7 |
| Dorcester | 62 | 461 | 134.5 |
| Wicomico | 54 | 884 | 61.1 |
| Somerset | 12 | 278 | 43.2 |
| Worcester | 32 | 386 | 82.9 |
| Unknown | 15 | 0 | -- |

The distribution of abortion by residence of patients is presented in Table 2. Reported abortions are given by county and area of residence, and births for calendar year 1970 are given to provide a basis for comparing different areas.

The ratios of abortions per 1,000 live births range from a low of 23 per 1,000 in Garrett County to a high of 213 per 1,000 in Baltimore City. The Baltimore Metropolitan Area, as expected, has the highest ratio (176) of any region, and the Northwest Area (52), and the Southern Area (39) are among the lowest. Actually, the lowest is the National Capital Area (32), but this figure is probably an artifact because of the large numbers of Maryland women having abortions in Washington hospitals and clinics.

Since these abortions were not reported in Maryland statistics (but births were), the ratio is artificially low. Nevertheless, the limited availability of abortions in some of the principal hospitals of this area probably contributes to this low ratio. When data on Maryland abortions in Washington, D.C. becomes available, this matter should become clear.

The complications of abortion are listed in Table 3, according to the weeks of gestation. As larger proportions of the abortions are being done early, the incidence of complications is diminishing. As can be seen, there were no deaths.

From the socio-economic aspect we feel that the ratio of private and service abortions to private and service deliveries is most significant. Our figures show that for the 40 nonfederal general hospitals in Maryland there were 56 per 1,000 more abortions per live births for the service patient than for the private. A comparison with past years shows this ratio is increasing as is seen in Table 4.

Table 3

| Complications | Total | | WEEKS OF GESTATION <9 | | 9-12 | | 13-16 | | 17-20 | | 21+ | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| None | 6710 | 86.50 | 1356 | 88.33 | 2943 | 89.12 | 1013 | 80.85 | 1316 | 84.09 | 82 | 80.39 |
| Died | | | | | | | | | | | | |
| Fever | 83 | 1.07 | 3 | .20 | 23 | .70 | 32 | 2.55 | 24 | 1.53 | 1 | .98 |
| Transfusion | 20 | .26 | 4 | .26 | 7 | .21 | 5 | .40 | 3 | .19 | 1 | .98 |
| Other | 164 | 2.11 | 13 | .85 | 25 | .76 | 41 | 3.27 | 80 | 5.11 | 5 | 4.90 |
| Unknown | 780 | 10.06 | 159 | 10.36 | 304 | 9.21 | 162 | 12.93 | 142 | 9.08 | 13 | 12.75 |
| **Total** | **7757** | **100.00** | **1535** | **100.00** | **3302** | **100.00** | **1253** | **100.00** | **1565** | **100.00** | **102** | **100.00** |

Table 4: Abortions per 1,000 live births as reported by 40 nonfederal general hospitals of Maryland.

| | 7-1-68/6-30-69 | 7-1-69/6-30-70 | 7-1-70/6-30-71 |
|---|---|---|---|
| Service Patients | 37.4 | 103 | 173.9 |
| Private Patients | 42.1 | 100.8 | 117.7 |


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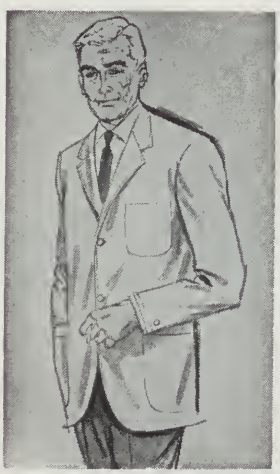
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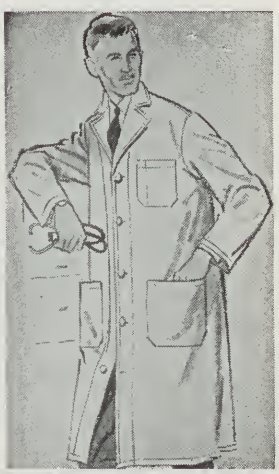


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ART AND HOBBY EXHIBIT

# ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

## MAY 3, 4, 5, 1972

BALTIMORE CIVIC CENTER

---

APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: **Chairman, Art and Hobby Exhibit**
**Medical and Chirurgical Faculty**
**1211 Cathedral Street, Baltimore, Maryland 21201**

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height .....

3. Electrical or other requirements: .....

.....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

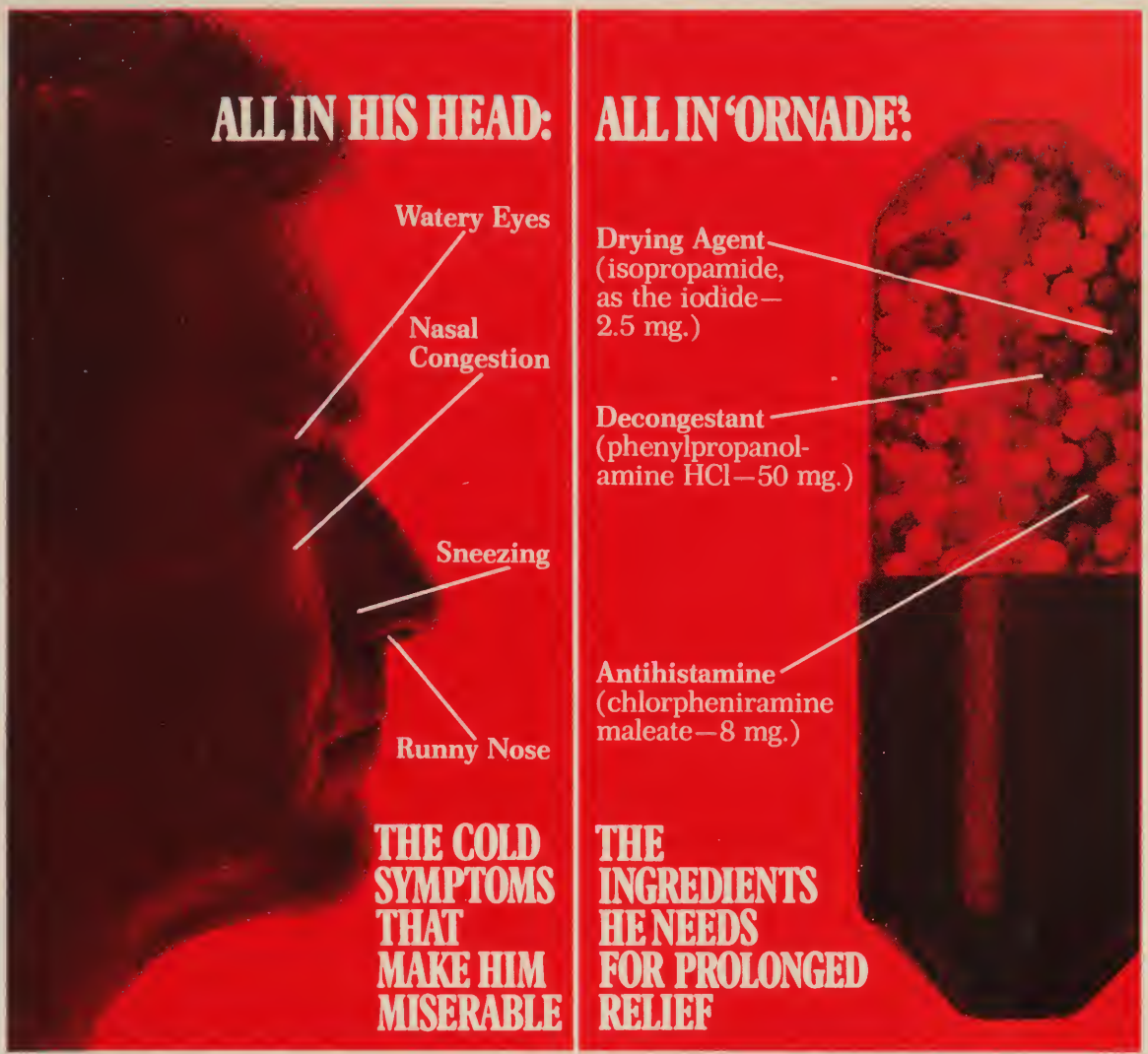
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An Art and Hobby Exhibit will be held during the 174th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted. However, it is strongly urged that APPLICATIONS be received in the Faculty office BY APRIL 15.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, May 2, 1972. They must be removed on Saturday, May 6, before 1:00 PM. The Faculty cannot carry insurance on exhibits. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies should cover the exhibit. Entries should be submitted as early as possible.



HOBBY DISPLAY—Great interest was shown in the Art and Hobby Exhibit at the 1971 Annual Meeting of the Medical and Chirurgical Faculty.




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# your medical faculty at work

**by John Sargeant**
**Executive Director**

**The Executive Committee met on Thursday, January 13, 1972, and took the following actions:**

1. Reviewed the 1972 budget, for which representatives of component societies had been invited to attend the meeting; and adopted it for recommendation to the Council for consideration at its January 20, 1972, session.

2. Agreed that the Faculty does have an interest in full-time physicians who are paid salaries and that salary and other information in this area should be developed at an administrative level.

3. Authorized a joint meeting with the Maryland State Dental Association Executive Board.

4. Approved an addition to the Nurse Protocol dealing with the administration of anesthesia by Nurse-Anesthetists.

5. Approved the following areas as being in acute need of a physician; so that consideration could be given to assignment of a National Health Service Corps physician to that area:
   Homestead/Montebello area of Baltimore City
   Garrett County
   Also determined that areas of Prince George's County could be approved, subject to approval of that component society.

6. Agreed to offer assistance to the Health Services Cost Review Commission in any capacity that it can help.

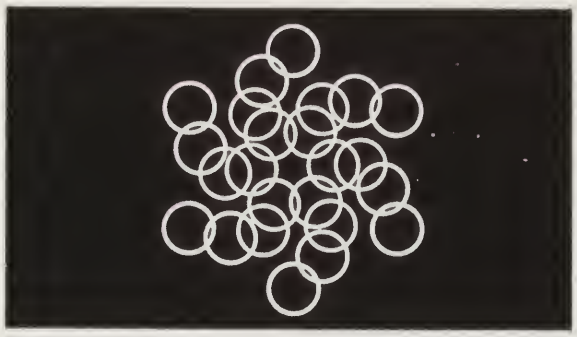
7. Received, for information, comments of the Maryland Society of Pathologists on the newly proposed Communicable Disease Regulations of the Department of Health and Mental Hygiene.

8. Authorized attendance of the Medicine and Religion Committee chairman at a Regional Workshop on this subject scheduled for New York City and payment of travel expenses related thereto.

9. Approved various Blue Shield recommendations for consideration of the Council.

10. Authorized submission of the name of the chairman, Committee on Continuing Medical Education, to the Maryland Hospital Association for appointment to that group's Professional Practices Commission.





From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

**alcoholism section**

# The Quarter-Way House: An Innovative Alcoholism Treatment Program

**(MRS.) WENDY MATERS, RN**
**Nurse-Coordinator**
**Alcoholism Services**
**University of Maryland Hospital**
**Baltimore**

Since January 1, 1970 the University of Maryland Hospital has operated an innovative quarter-way house program for sick alcoholics. Beginning with a five-bed experimental unit, the hospital now provides an inpatient program of rehabilitation, re-education, occupational therapy, and follow-up at the 20-bed Tuerk House unit.

It offers a 14-day recovery program in a home-like atmosphere. Tuerk House is located in the community and is close to the hospital.

The original plan was to have a ten-bed unit for male alcoholics, in conjunction with a nursing home. Patients being admitted to this unit would come from the University of Maryland Hospital Emergency Department and inpatient wards, assisting the hospital by reducing the length of stay of male alcoholics to those areas. Patients being admitted to this facility would no longer need treatment within a general hospital, but would need a place to recover from their alcohol intoxication.

The State Department of Health and Mental Hygiene provided a grant for a nurse-coordinator, a senior counselor, and four other counselors to run this operation on a 24-hour basis, seven days a week, under the direction of a psychiatrist.

The proposed plan to run this operation in conjunction with a nursing home did not materialize, and another facility had to be found. A religious organization, owning a house located 3.5 miles from the hospital, was very understanding of the problem. It provided the staff with some rooms on a temporary basis until a more suitable facility could be found. The Department of Social Services agreed to pay Christian Outreach of Maryland (operating this facility) $5 per day per person for a total of 14 days after being admitted via University Hospital.

This five-bed unit opened in January 1970 and continued for five months. It was an invaluable experience to the staff, and became the guideline to the existing program. It should be noted that of the first 20 men that were admitted, eight have maintained sobriety. This high success rate may be attributed to the fact that this was a small unit and the very close relationship between the staff and the patients.

### Beginning of Tuerk House

While this small unit was operating, the staff was looking toward the future and a more suitable permanent facility. It was obvious that geographically the place should be close to the hospital for several reasons. First, it was found that many of the men needed to make return visits to keep clinic appointments, or to the emergency room if they developed other illnesses. Secondly, the hospital alcoholism program was extending its services, an alcoholism clinic and group therapy sessions, which could be utilized by the patients in the Quarter-Way House. The third reason for bringing this facility close to the hospital

was for educational purposes. If students from the professional schools were to be involved in utilizing this facility, it should be easily accessible.

University of Maryland Hospital was not prepared at this time to administer the unit; however, they were prepared to support it in whatever ways they were able. The advice from the Maryland Division of Alcoholism Control was that the community should be involved in preference to having the house operated by private enterprise.

Several existing half-way house organizations were approached, but the consensus of the staff was that this operation would be revolutionary in the treatment of alcoholism with new ideas and methods being implemented; therefore, a new organization would be needed.

People interested in the field of alcoholism were contacted in regards to forming an organization which would be responsible for management of a house. At a meeting held in April 1970, "Quarter-Way Houses, Inc." was established. The responsibilities of Quarter-Way Houses are those of an innkeeper, providing room and board.

In June 1970, Quarter-Way Houses, Inc. signed a lease with the owner of the property located at 106 North Greene Street (just two city blocks from the hospital).

This house, named "Tuerk House," is licensed as a multiple dwelling meeting the requirements of the city housing, health, and fire departments and accommodates 20 men. By mid-July, the first patient was admitted and by August all 20 beds were occupied. There has been full occupancy since that time. A total of 717 patients has been admitted this past year, or an average of 59 men per month. Although it is desirable for all patients to stay for the full 14 days, there is no way of preventing a person from leaving at any time. The average length of stay has been stable throughout the year at ten days. This is a much higher average than had been anticipated.

### House Rules

Rules were made for the patients and have been closely adhered to. There are two that should be mentioned. The first is that there will be no drinking of alcoholic beverages on the premises. Anyone leaving and returning intoxicated will not be able to remain in the house. If they so desire, arrangements are made for them to be admitted to the shelter or another facility; however, this is seldom the case.

The second rule is in regards to readmission to the unit. The Department of Social Services stated that payment at the rate of $5 per day, will only be made for six sessions within such a facility, and not more than once within any calendar month. With this in mind, a patient may not be readmitted for a period of six weeks. Whether it would be conducive at this time for a patient to be readmitted is at the discretion of the counselor in the emergency department who has access to the previous discharge summary.

Most of the patients come to Tuerk House via the hospital emergency room; however, a few patients are referred to this facility directly from an inpatient area of the hospital.

### The Program

The senior counselor has been responsible for developing the daily program for the patient and, with only 14 days to help the men, an active program has been put into effect.

One hour every morning, a counselor presents a lecture on an aspect pertaining to alcoholism. He may use slides, tapes, or films to present his topic. In the afternoon, the patient group discusses the morning lecture. These lectures and discussion groups follow the same cycle on a weekly basis. If a man is too sick to actively participate the first week, he may understand more during the repeat session the second week.

Each patient is assigned to one of three counselors who are responsible for the needs of that man during his stay. The counselor will take a case history and meet individually with the patients for at least three one-hour sessions, usually on the second, sixth, and tenth days. After the final session, the counselor writes a discharge summary and relates the needs of the man to his fellow counselor responsible for all discharges. Group therapy sessions are an important part of the activities of the program. There are four groups at the hospital that the men attend. AA conducts four meetings in the house, of which the inpatients attend two. The other two AA meetings are open to anyone, and many of the men who have been through the program return to these meetings.

It has been found that the alcoholic must be kept fully occupied if he is to remain the 14 days. Occupational therapy is of paramount importance. Reading material is available. When physically able, each man is assigned to maintenance duties within the house. He may assist the cook, clean the house or, if he has a special trade and so desires, may assist with the renovations that are constantly in progress. Recreational activities have been limited this past year. Offers have been made for the patients to use the gym in the nearby Psychiatric Institute and a swimming pool at one of the schools.

The medical needs of the patient have been well-provided for. The nurse-coordinator visits the unit daily to see all new patients. She reviews the physical examination form which has accompanied the patient from the emergency room. She sees that any medication orders which have been prescribed by the physician are administered, and any clinic appointments that may be needed are made. She administers to any medical needs as indicated. There is a very good working relationship with the hospital. A 14-day plan for a high calorie, high protein diet was set up by the dietary department. The pharmacy is most cooperative in filling prescriptions.

Three patients who have required surgery have been admitted to Tuerk House. After detoxification, the patients were admitted to the hospital. Upon discharge from the general hospital, they returned to Tuerk House for the remaining days.

Some patients have required psychiatric evaluation and longer treatment in a state hospital. Eight patients have been referred to the psychiatric open clinic, of which three of 717 patients have been sent to state hospitals.

One morning each week, the director of the program, a psychiatrist, visits the unit. He sees all patients with medical or psychiatric problems and also those who desire to start on *Antabuse* (disulfiram). The day before his visit, related lectures and discussions are held. Since medical rounds started last October, 194 Tuerk House patients have been seen. Outpatients of Tuerk House may return to this clinic for prescription refills or to see the physician.

### Using Medical Students

To provide the above program for 20 men was nearly an impossibility for the staff of five counselors. Therefore, a supplementary grant was requested in November 1970 for medical students to work as counselors during the night hours. This grant was approved, and medical students started in the program January 1971. These students have been rotating through the program. They have assisted with individual counseling, participated in group sessions, and cared for the needs of the patients. The students meet with the director of the program on a routine basis to discuss case histories, and participate in educational lectures on alcoholism.

Extensive coverage of this unique facility has been given by television, radio, and newspapers. The staff participates in panel discussions, and has presented the program to a variety of agencies in both the city and counties. Many visitors from both in and out of state have come to see Tuerk House.

It may be noted that in the first few months of operation, 80% of the patients were homeless. As the program became known, several companies having no other such facility to utilize started referring their employees to the Tuerk House for treatment of alcoholism. The percentage of homeless has decreased to 50%. There is no catchment area. Patients are referred from the courts, Department of Probation and Parole, other hospitals, and agencies. Some are from outside the city limits and a few from out of state. No beds are held open. It is at the discretion of the counselor assigned to the emergency room as to who will be admitted. With an average of 400 alcoholics a month presenting themselves in that area for treatment, there is no problem in keeping the unit fully occupied.

### Follow-Up

The follow-up part of the program may be considered to be the most important area. As stated earlier, one counselor was assigned for discharge of all patients. It was the counselors' convictions and success with sobriety that formulated the development of the follow-up program. They felt that the alcoholic—if given the opportunity—could become a useful member of the community again. For the alcoholic to maintain sobriety after discharge from the Tuerk House, he would have to live in a conducive environment with suggested groups available such as AA, and have access to therapy sessions in hospitals and clinics.

By careful study of the existing half-way houses in the city, it was felt that only a few were suitable. Most left a lot to be desired and have not been used by this program. A six-bed half-way house directly connected to Tuerk House has been in operation since October 1971 under the direction of the follow-up counselor. This has been very successful. It has been self-supporting and the men have been in close contact with the program.

The follow-up counselor has developed a good working relationship with city agencies, industry, private concerns, and families. The men who are homeless must have a place to stay and a job. Extensive work has been done on the part of this counselor to encourage businesses to hire the alcoholic. The State Department of Employment Security has been very understanding and helpful as has the City Department of Social Services. It is important that these two essentials of life be met without too much stress on the man if he is to maintain sobriety.

The men are encouraged to return to Tuerk House just to keep in touch. Some 50 men a month make from one to ten visits. It may be to discuss problems, to participate in groups, to attend the clinic, or just for social reasons.

### Program Evaluation

Success of the program may be measured in many different ways. Total sobriety of all patients is not expected. However, it is estimated that 33% of the patients for this past year are sober today, the length of sobriety being from one to 12 months. Five percent have returned to their families, and 8% returned to their jobs. Four percent are not incarcerated due to alcoholism because they have jobs, and 2% are in some type of training. The counselor who has been responsible for discharges and follow-ups was assigned a student from Community Maintenance and Home Services for field placement. It became obvious that a larger staff was needed for this area. The student remained on the staff on a temporary basis until the end of the fiscal year.

Tuerk House is just one component in the overall comprehensive program in Alcoholism Services and Education at the University of Maryland. This facility has been a resource for the training of students from the professional schools of nursing and medicine. Trainees from the Baltimore City Health Department Alcoholism Counselors School, Community College of Baltimore Mental Health Technicians course, and Community Caretakers course in alcoholism have had field placements in the House.

The original goals have been more than realized for the past year. Because of the loyalty, dedication, and concern of every staff member, this program achieved its success.

It is not possible to measure human lives and needs in dollars and cents. However, the cost per man per day is $14.50. Total annual cost of this program was $120,654. The State Department of Health and Mental Hygiene provided $87,509; the remaining $33,145 was supplied by the Department of Social Services. All 717 patients would have been admissions to state hospitals at a far greater expense. It also may be noted that the men who have returned to the community and are working are no longer supported by state agencies.

In the coming year, if sufficient funds are made available for more staff, it is hoped that the quality of care can be improved and more activities added to the program. It is also planned to extend the follow-up services which are increasing constantly.





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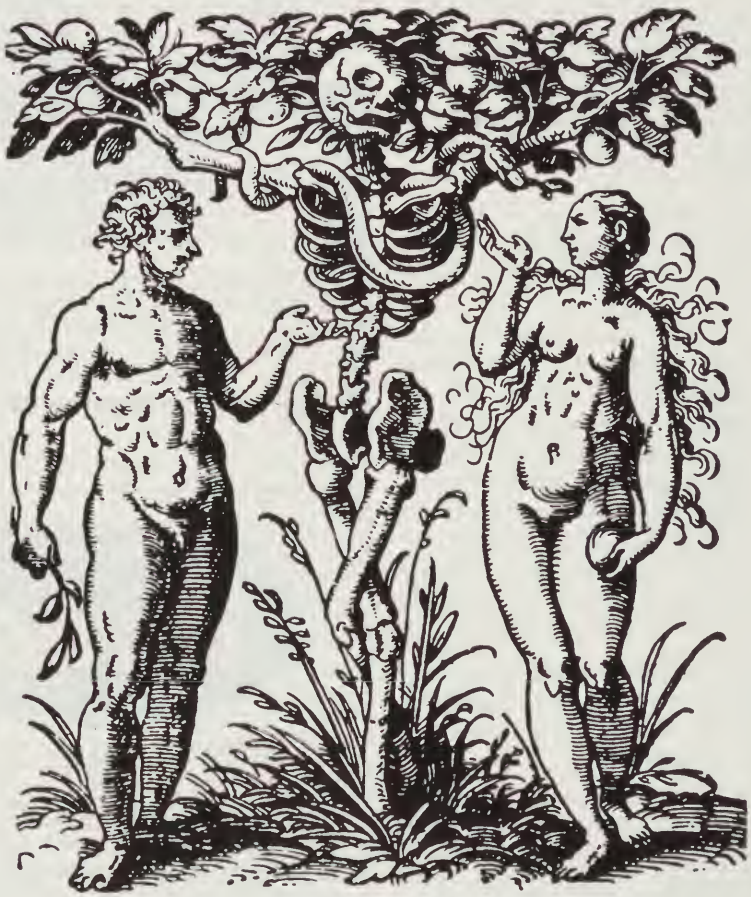
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# In acute gonorrhea

## (urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



**Sterile Trobicin®**
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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**Warnings:** Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

*Safety for use in infants, children and pregnant women has not been established.*

**Precautions:** The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-

# Trobicin®

## sterile spectinomycin dihydrochloride pentahydrate, Upjohn

## single-dose intramuscular treatment

**High cure rate:* 96% of 571 males, 95% of 294 females**
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

**Assurance of a single-dose, physician-controlled treatment schedule**

**No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed**

**Active against most strains of Neisseria gonorrhoeae in vitro** (M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.
*Male*—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
*Female*—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
*Susceptibility Powder*—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

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**PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON NOSOCOMIAL INFECTIONS, Center for Disease Control, August 3-6, 1970, published by the American Hospital Association, Chicago, Ill., 1971.**

This conference was the result of a concern on the part of the American Hospital Association, the American Public Health Association, and the Center for Disease Control regarding nosocomial infections, which remain a public health problem of major importance.

The purpose of the conference was to bring together a number of individuals working on the problem so they could share their experience and knowledge of the epidemiology of nosocomial infections, identify effective systems of reducing, controlling and preventing such infections, and delineate areas in which further investigation is needed.

These proceedings represent discussions by outstanding researchers from throughout the world. It provides a useful source of information for those working to control such infections.

**DIFFERENTIAL DIAGNOSIS, The Interpretation of Clinical Evidence, by A. McGehee Harvey, MD, and James Bordley, III, MD, W. B. Saunders Company, Philadelphia, 1971.**

This is an abridgment of the second edition of this publication, thus bringing it into the market for medical student use. The second edition (1970) was a much larger and more costly volume than the first edition (1955).

The abridgment has been accomplished without compromising any, except the last of four factors: general discussion of the subjects in each chapter, addition of new chapters, an increase in the number of references cited, and a great increase in the number of illustrative cases.

It is the hope of the authors, distinguished physicians in the Baltimore community, that this will enable the book to be used by students, residents, and others who would be deterred from paying a higher price for the complete text of the second edition.

Those who wish to test their skill in the differential diagnosis of "unknown cases" should refer to the complete second edition, available in most medical libraries.

**MANAGEMENT OF HIGH-RISK PREGNANCY AND INTENSIVE CARE OF THE NEONATE, by Ralph C. Benson, MD, and S. Gorham Babson, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

The second edition of this publication has been expanded to concern all neonates "in trouble" and the title has been changed accordingly. It is an excellent reference work for pediatricians, obstetricians, and all others involved or concerned with intensive care units for the newborn, as well as other areas of high risk infants.

Credits go to many distinguished physicians who all assisted in the preparation of this edition.

**SYNOPSIS OF OPHTHALMOLOGY, by William H. Havener, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

This is the third edition of this publication which contains usable, detailed information about the skills and knowledge that could reasonably be expected of a practicing physician.

The arrangement of the text is planned in terms of functional categories rather than the usual anatomic classification.

The author, in his preface, makes certain comments which we believe to be worthy of note. They include:

". . know that one in 25 of your patients will lose useful sight in one eye during his lifetime. Half of such blindness is preventable by today's medical knowledge — if applied. Seemingly trivial details may make the difference between a well-treated, seeing eye and visual tragedy. I sincerely hope that such details, as presented concisely within this book, will help to prevent unnecessary blindness and disability."

**HANDBOOK OF POISONING, seventh edition, MD, Lange Medical Publication, Los Altos, Calif., 1971.**

The purpose of this Handbook is to provide a concise summary of the diagnosis and treatment of clinically important poisons.

The book is organized into industrial, agricultural, household, medicinal, and natural hazards.

This soft-cover publication provides a ready reference to the practicing physician, as well as medical student. It is one that will add to the value of medical libraries everywhere.



# Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

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Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

# the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences in their activity levels and estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

*References.* **1.** Editorial: Oral Contraceptives: Which Pill for Which Patient? Patient Care 3:90-115 (Feb.) 1969 and 4:135-145 (June 15) 1970. **2.** Greenblatt, R. B.: Progestational Agents in Clinical Practice. Med. Sci. 18:37-49 (May) 1967. **3.** Kistner, R. W: Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W. The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H. Clinical Evaluation of Side Effects of Current Oral Contraceptives, J. Reprod. Med. 6:50-55 (Feb.) 1971. **6.** Orr, G. W. Oral Progestational Agents: Therapy and Complications, S. Dakota J. Med. 22:11-17 (Jan.) 1969.

## the Ovulen phase

Most women* with a **balanced hormone profile** and **normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breast feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.'s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slight progestogen dominance. It has an excellent record of patient acceptance.

# Ovulen®

Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information, see following page.



## the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

# Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg

Each pink tablet in Ovulen-28™ and Demulen™-28 is a placebo, containing no active ingredients.

Both Ovulen and Demulen are available in 21- and 28-pill schedules.

## the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

# Enovid-E®

Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.

# for the 3 phases of Eve:

## a family of O.C. products

# Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

# Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possibl influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrena hepatic or uterine function awaits further study. A decrease in glucose toleranc has been observed in a significant percentage of patients on oral contracep tives. The mechanism of this decrease is obscure. For this reason, diabetic pa tients should be carefully observed while receiving Ovulen or Demulen therap The age of the patient constitutes no absolute limiting factor, although treatmen with Ovulen or Demulen may mask the onset of the climacteric. The pathologis should be advised of Ovulen or Demulen therapy when relevant specimens ar submitted. Susceptible women may experience an increase in blood pressur following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contracep tives**—A statistically significant association has been demonstrated betwee use of oral contraceptives and the following serious adverse reactions: thrombo phlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relation ship has been neither confirmed nor refuted for the following serious advers reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving or contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdom inal cramps and bloating), breakthrough bleeding, spotting, change in menstrua flow, amenorrhea during and after treatment, edema, chloasma or melasm breast changes (tenderness, enlargement and secretion), change in weig (increase or decrease), changes in cervical erosion and cervical secretions, sup pression of lactation when given immediately post partum, cholestatic jaundic migraine, rash (allergic), rise in blood pressure in susceptible individuals an mental depression.

Although the following adverse reactions have been reported in users o oral contraceptives, an association has been neither confirmed nor refute anovulation post treatment, premenstrual-like syndrome, changes in libid changes in appetite, cystitis-like syndrome, headache, nervousness, dizz ness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiform erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contra ceptives: hepatic function: increased sulfobromophthalein retention and othe tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X thyroid function: increase in PBI and butanol extractable protein bound iodin and decrease in $T^3$ uptake values; metyrapone test and pregnanediol dete mination.

**References: 1.** Royal College of General Practitioners: Oral Contrace tion and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 196 **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonar Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearin Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Inves gation of Relation Between Use of Oral Contraceptives and Thromboembol Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwe P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboem bolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Ame J. Epidem. *90*:365-380 (Nov.) 1969.

SEARLE Products of SEARLE & CO.
San Juan, Puerto Rico 00936

# Enovid-E®

norethynodrel 2.5 mg./mestranol 0.1 mg.

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output gonadotropins from the pituitary gland. Enovid-E depresses the output of bo the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note*, *Contraindications*, *Warnings*, *Precautions* and *Adver Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E ar should be observed when prescribing Enovid-E.

SEARLE **Enovid-E®**

brand of norethynodrel with mestranol

Product of G. D. Searle & Co.
P.O. Box 5110, Chicago, Illinois 60680
*Where "The Pill" Began*



"For generations my family has insisted on Donnagel®-PG," says active young matron Mrs. T. Farnsworth Lipp (of the Upper Lipps), shown here with her charming son. "All the benefits of paregoric—without the unpleasant taste, don't you know? And Junior thinks Donnagel-PG tastes so much like bananas that I never worry about a slip between spoon and Lipp."

## A Matter of Taste

With or without a silver spoon, a most tasteful solution in treating acute, non-specific diarrheas: all the benefits of paregoric, without the unpleasant taste. Donnagel®-PG treats accompanying cramping, tenesmus, and nausea as well as the diarrhea itself. Instead of unpleasant-tasting paregoric, it contains the therapeutic equivalent, powdered opium, to promote the production of formed stools and lessen the urge. And it provides the demulcent-detoxicant effects of kaolin and pectin, plus the antispasmodic benefits of belladonna alkaloids. And a good banana flavor to baby any taste.




# Donnagel®-PG

Donnagel with paregoric equivalent

℞ Available on oral prescription or without prescription under limited circumstances as modified by applicable state law.

Each 30 cc. contains: Kaolin, 6.0 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (Warning: may be habit forming); Sodium benzoate (preservative), 60.0 mg.; Alcohol, 5%. A.H. Robins Company, Richmond, Virginia 23220

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Robitussin
Robitussin-DM
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4 FL OZ
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Cough Calmers

# clear the tract!

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

*For coughs of colds and "flu"*

## Robitussin®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Alcohol, 3.5%

*For unproductive allergic coughs*

## Robitussin A-C®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

*Non-narcotic for 6-8 hr. cough control*

## Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Dextromethorphan hydrobromide ..... 15.0 mg.
Alcohol, 1.4%

*Clears sinuses and nasal stuffiness as it relieves cough*

## Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

*Robitussin-DM in solid form for "coughs on the go"*

## Cough Calmers®

Each Cough Calmer contains:

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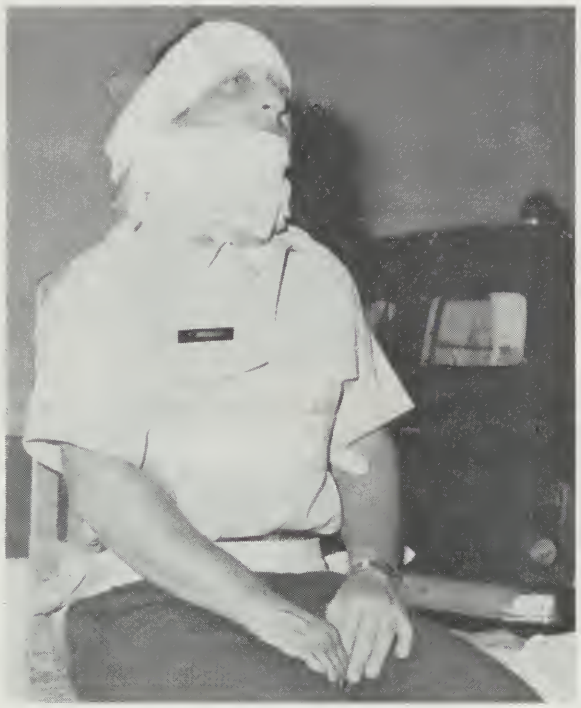
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| ROBITUSSIN A-C® | ● | ● | | | |
| ROBITUSSIN-DM® | ● | | ● | | ● |
| ROBITUSSIN-PE® | | | | ● | ● |
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# EMERGENCY MEDICINE

**The Medical and Chirurgical Faculty of Maryland sponsored a symposium on March 31, 1971. Held at the St. Joseph Hospital in Towson, it was titled "Practical Emergency Department Service."**

**John B. De Hoff, MD, chairman of the Subcommittee on Emergency Medical Services of the Committee on Preventive Medicine served as chairman for the day's activities.**

**This issue of the** Journal, **in the section that follows, includes representative papers and panel discussions that were devoted to various phases of emergency medicine.**

**Dr. De Hoff has written an editorial/article, "Emergency Departments: Multi-Purpose Medical Centers," to serve as an introduction and to set the scene for your reading of the special section.**

**The 1972 emergency medicine symposium will be held on March 22 at the Sinai Hospital in Baltimore and will be called "The Unconscious Patient in the Emergency Department." A detailed program and reservation form will be mailed to all members of the Faculty and to others on request.**

# Emergency Departments: Multi-Purpose Medical Centers

JOHN B. De HOFF, MD, MPH
Deputy Commissioner of Health
Baltimore City Health Department

**It is foolish to call emergency departments the general practitioner or family physician of today. It is folly, not because emergency departments do not provide general services to all patients, and not just because emergency departments *per se* cannot be physicians. It is fallacious because such a description by no means adequately describes what a good emergency department is or does or, for that matter, what it should be or do.**

We are dangerously deceived when our attention is diverted from the complex realities of modern emergency medical care by the use of a comforting, reassuring, outmoded description like "general practitioner." Worse, efforts to reconceptualize the emergency department as a unique element in a changing medical care delivery system are imperiled.

Emergency departments have been considered to be hospital property. They are staffed by hospital employees, used for the training of hospital staffs, supplied from the hospital's depots, supported by hospital services, and they are established — or closed — at the hospital's discretion. An emergency department cannot exist without a binding relationship to a hospital. Even though self-employed physician groups may provide their professional skills on a fee-for-service basis, emergency treatment centers must be closely related to a hospital of equal proficiency if the care of dangerously ill persons is to be continuous.

True, emergency services report an increasing number of patients who have problems which do not need immediate attention. Emergency staffs, already hard pressed by the care of critically injured or ill patients, often consider these ambulatory sick people to be an unwarranted additional burden. In an effort to provide improved care for the relatively minor illnesses, some hospitals have recognized anew[1] that emergency departments and outpatient departments are parts of general ambulatory care, and outpatient department service hours have been extended to relieve the burden on emergency department staffs and facilities.

One begins to see now the beginning of a medical system concept. When emergency departments were hospital property they were of relatively little concern to the private practicing physician, but as neighborhood physicians moved away from major hospitals, and as hours and modes of practice changed[2], hospital outpatient care increased in importance. This growth of hospital-based ambulatory care has been accelerated by the practice of patient referral to emergency departments by physicians or their answering services, by the convenience of hospital facilities (minor surgery, EKGs, X-ray, etc) for visiting staff, and by the change from a traditional cry of "Call a doctor!" to "Call an ambulance!"

Private practicing physicians always have provided ambulatory and emergency patient care services. Now they share this responsibility for patient care with hospital-based services. Hospitals, which either did not perceive this relationship and its modern development, or which were reluctant to make appropriate adjustments, are now hurrying along with expansion plans for both emergency departments and outpatient departments.

Public health agencies, too, have not been any more expert than private physicians or hospitals in this new conceptualization of a medical care system, until lately. Early efforts were directed to the improvement of ambulance services, and then only after repeated proddings by the American College of Surgeons and other interested groups. In 1966 Baltimore became the first locality in Maryland to develop ambulance regulations.[3] The ordinance which required these was the result of a private citizen's interest, and reflects a growing public concern for better medical emergency facilities. This concern includes emergency personnel training and area-wide coordination of emergency treatment centers.

The developing Baltimore area emergency care system is already using new types of emergency service personnel. Sinai Hospital has found that "patient advocates," trained aides working anywhere in the emergency department, expedite care for patients at any phase of their visit.[4] Baltimore City Health Department trains alcoholism counselors, and many hospitals have found them and their special skills to be invaluable in the care of both acute and chronic alcoholics. Baltimore County General Hospital has an intensive formal training course for emergency

technicians.[5] The State Department of Health and Mental Hygiene has prepared a special course, and furnishes instructors for ambulance attendants.

Emotional illnesses often stretch the patience of the most earnest emergency service staff members. Mental health associates, trained in Maryland's community colleges, are very useful in the management of acute conditions and their follow-up. Morgan State College and the Maryland Consortium of the Health Sciences have developed additional training leading to a Bachelor of Science degree for mental health specialist. The first class will be graduated in June 1972.

The Baltimore City Medical Society is a charter member of the Maryland Consortium, as it is of two other health care corporations.[6] The Society, working through these corporations to improve the health care system, believes that better organization of care delivery will prevent many illnesses from reaching a state critical enough to require emergency department care.

Emergency departments in the Baltimore area have been subjected to intense study by The Johns Hopkins School of Hygiene and Public Health[7, 8] and most recently by the Regional Planning Council (to be reported). Private physicians and those in charge of hospital emergency departments have supported and participated in these studies, both directly and through an informal organization of Baltimore area emergency department chiefs (MED-HEADS), and through the Faculty's Subcommittee on Emergency Medical Services which has representation from every Maryland hospital emergency department.

The keys to effective system development, management, and control are data, accurately recorded, adequately documented, systematically retrievable, expertly interpreted, and selectively reported. In order for any changes to represent improved services, rather than simply more of the same thing, physicians and planners need to know what they are changing and why. They need to know, not only what diseases to prepare for, but who will have them, when and why, and from where will the patients come. The planners and public health agencies, once they know that much, can effectively reduce the number or severity of medical emergencies.

Prevention is always mentioned last. This ranking belies its importance. Prevention should be first in our thinking, except that it is based on what has already happened, and is thus an afterthought. Good epidemiologic data, selectively reported and expertly analyzed, is the start of preventive action—but only the start.

It takes more than simple knowledge of accident causation or disease exacerbation for prevention to be applied. Public support is needed to obtain improvement of unsafe highways, strict requirements for driver license retention, prevention of burns due to flammable clothing or poorly designed dangerous household appliances, management of alcoholism and drug abuse, reduction of gunshot wounds, and careless sports injuries.

Emergency medical services urgently require the attention of the medical profession and public health agencies, hospital administration and trustees, patients, and other consumers, if emergency departments are to be adapted or redesigned or rebuilt to meet ever-changing modern needs. Right now, communication networks are primitive; specialized personnel training has just begun; coordination of treatment center activities for intercenter patient transfer has hardly been roughed out. Assured adequate funding is needed for both the simple problems of indigent people and the complex problems of all seriously ill patients. And modern techniques of documentation and record management designed especially for a total emergency system are overdue.

Physicians, through Faculty committees and their local societies, can help to form public opinion which will lead to correction or prevention of conditions which clog the emergency care system. But physicians who speak for the Faculty should have the full support of all members.

One means of securing the understanding which leads to support was the first annual symposium on the practical aspects of emergency services, sponsored by the Subcommittee on Emergency Medical Services. Representative articles from that symposium are included on the pages that follow.

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# Equipment: The Good and the Dangerous

**HAROLD EVANS**
**Captain, Ambulance Division**
**Baltimore County Fire Department**

Ambulances may be outfitted with a large variety of supplies, equipment, and devices. Some are extremely good, and some poorly designed and inadequate. Care must certainly be exercised when purchasing supplies and equipment.

Some of the equipment and devices carried on the ambulances in Baltimore County were developed through the cooperation of the men operating the ambulances.

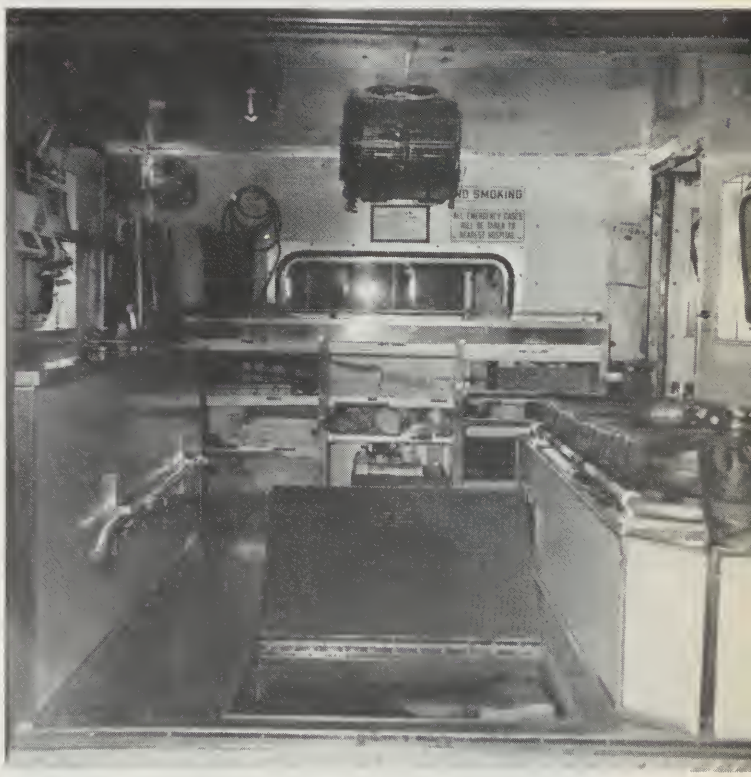
I have succeeded, during my tenure as Captain of Ambulance Service, in standardizing the ambulances and the equipment carried on them so that any of our ambulance personnel may work on any of our ambulances with complete familiarity.

I have attempted to use only devices that are relatively easy to operate, and those that may easily be kept ready for use.

There are many oxygen-breathing devices that may be put on ambulances. Some units are extremely heavy, weighing as much as 110 lb. Should it be necessary for a man to carry one of these up three floors, he would probably need the device himself when he reached the patient. Consequently, we use a little portable device known as a smooth-flow regulator that can be operated simply but efficiently. In fact, its operation is so uncomplicated that after 15 minutes of instruction, anyone can operate it skillfully.

The function of the smooth-flow regulator valve of an oxygen tank (Figure 1) is to supply a controlled quantity of oxygen to assist breathing. It is released from the cylinder so that there will be no fluctuation due to decreasing pressure within the cylinder.

This regulator is attached to a 21-cubic-foot capacity cylinder of oxygen in a leather bag with hooks attached, so that it may be attached to the cot. A disposable, nonrebreathing mask with a one-way valve, which allows the breathing of 100% oxygen, completes the unit. (These masks are presently being used in intensive care units of hospitals.) Some special advantages of this mask are the one-way valve to eliminate breathing any mixture of $CO_2$ and air, its inexpensiveness (approximately $1.30 a mask) and the reservoir bag affixed to the bottom of the mask which allows the ambulance crewman to observe the patient's breathing at all times.




BALTIMORE COUNTY emergency equipment as viewed from the rear of an ambulance.

The device shown in Figure 2 allows the patient to receive oxygen continually, from when it is first administered until he is safely in the hands of hospital personnel.

In addition, the ambulances of Baltimore County are outfitted with "Elder" valves. They are plunge-pressure breathing machines which are used specifically for nonbreathers. If the lungs fill with foreign material, this type valve will not operate. When this happens to patients being transported by the ambulances of our service, the crews are instructed to immediately begin mouth-to-mouth resuscitation.

The stretcher may be fitted to accommodate this oxygen equipment inexpensively by attaching hooks to the frame of the cot (Figure 3).

The addition of the oxygen equipment to the cot adds relatively little weight (9 lb).

In the ambulances, there is an additional smooth flow regulator attached to an 82-cubic-foot oxygen cylinder which provides a dependable supply of oxygen enroute to a medical



Figure 1



Figure 2

facility. To change over from the portable unit smooth flow regulator, the crew member turns the oxygen on in the large cylinder and then removes the hose from the portable unit and slips it on the fitting of the smooth flow regulator. This allows the patient to receive an uninterrupted oxygen supply enroute to the hospital. (A spare 82-cubic-foot cylinder of oxygen is kept in each fire station in which an ambulance is housed.)

The cost of the complete oxygen therapy equipment used on our ambulances is between $225 and $250. This is considerably less than the cost of other available oxygen equipment. (This does not include the rental cost of the large oxygen cylinders which may not be purchased outright.)

Several inflatable plastic splints are also carried in each of our ambulances and, in addition, a special elbow splint, perfected by members of our ambulance service, is also included. The elbow splint can be applied in one minute with the elbow joint in any position. The splint may then be locked in that position and held firmly by wrapping curlex roll bandage around the splinted elbow. See Figure 4.

Another special splinting device, the Hare traction splint, is also standard equipment on our ambulances. Only persons well-trained in its use should apply this splint, since special caution is necessary to avoid further damage to the fractured limb. Once this splint has been applied, a ratchet device on the splint is utilized to put enough traction on the limb to immobilize it, reduce the pain and increase circulation to near normal. An experienced man can complete splinting with this device in approximately 1½ minutes.

Injuries to the vertebrae of the upper spinal column are occurring with increasing frequency. Possible paralysis or even death is occurring in many of these cases as a result of these victims being pulled from vehicles, or otherwise moved without support for the back. For this reason, I have had half backboards constructed and installed on all the ambulances of our service, as shown in Figure 5.

This board (Figure 6) with cervical collar and straps was made with the cooperation of a local high school woodworking shop at a cost of less than $25 each.

Some other equipment and devices carried on our ambulances, which facilitate the care of the sick or injured, are disposable maternity kits containing everything necessary to assist delivery.

We also have an aspirating device that derives its vacuum from a booster on the engine of the ambulance, as pictured in Figure 7.

A special translift sheet (Figure 8) is used for transferring a patient from the ambulance cot to the hospital bed. We also have a portable cutting device that derives its power from a portable air cylinder. It is used to open vehicles to permit extrication of victims.

To record the pertinent data of each emergency, our ambulances are supplied with a quantity of triple copy trip records. These reports are designed so that all necessary data can be recorded quickly and accurately. One copy is left at the hospital, the original is retained in fire headquarters, and the third copy is kept in the station housing the ambulance.



Figure 3



Figure 4



Figure 5



Figure 6



Figure 7



Figure 8

# CERTIFICATION: HOW TO DO IT EFFECTIVELY

**JAMES D. CARR, MD**
**Assistant Commissioner**
**Local Health Services**
**Baltimore City Health Department**

The most important word in considering the topic "Certification: How To Do It Effectively," is "effectively," since an ambulance service works in what is essentially a political environment. And effectiveness and political environment don't necessarily always go hand in hand. I wouldn't say that political environment mitigates effectiveness, but there are times when it certainly doesn't help. So, things move slowly, much more slowly than some of us would like.

Now, I want to make this crystal clear. I am not—in the rest of what I have to say— talking about Captain Evans' group or Chief McMahon's group, and for two reasons. In the first place, some of what I have to say certainly does not apply to them. Secondly, if I know Marty McMahon half as well as I think I do, if I left any confusion exist, he would run me straight back into Baltimore City.

The Baltimore City Fire Department ambulance service is one of the best in the nation. I wish I could feel the same way about commercial ambulances but, to be perfectly frank with you, I don't.

Undoubtedly, the most important piece of equipment in the ambulance is the attendant or the driver-attendant.

To insure that we have qualified attendants, we have a licensing procedure in our department. An application form is filled out, and the applicant undergoes a physical examination. The application form then goes to the director of our Bureau of Environmental Hygiene and he makes certain inquiries concerning difficulties with the Department of Motor Vehicles or the Police Department of Baltimore City or Baltimore County. Two letters must also be presented by "respectable" citizens.

Another thing that must be included in a program for effective licensing is constant review. We examine each ambulance and each location a minimum of twice a year. That may be enough; it may not be; I don't know. At times, we also stop outside the accident room at one place or another some night and enter the ambulance after the attendants have delivered the patient to check for equipment.

One of the things that you will find is that sometimes some piece of equipment is missing, some small violation is made. But I don't think that this is half as important as the fact that the people who are hired for these jobs are sometimes not fully capable of performing their duties. Some have 20/200 vision and no spare glasses; some are 5'11" tall and weigh 273 lb. Can you imagine how much good such a person would be when he got up to the third floor with a litter carrier?

Another important factor is the man's personality. I simply won't license a man who is constantly clashing with the law. I won't do that for one simple reason: I don't think he's mature enough to be trusted with the care of helpless people.

The more advanced the training, the better. Right now I think we need more comprehensive histories and physical examinations. The little form that you give to a man to complete (you do a history, you do a physical) actually is not very effective. And it gives a false sense of safety, because he has not had what I think is a really good physical examination and we have not found the incipient things. And I think it ought to be done in one place by one qualified group of people, and every applicant ought to be measured by the same standards.

Finally, I think that we've got to think about more advanced training, continuous retraining, and centralized administration. And if we don't do those things I don't think we're going to get anywhere. I would like to see a licensing situation either set up by the state, or if Baltimore City wants to do it as a unit, one set up in conjunction with or under the aegis of the fire department so that we would have good standards, standards that apply all the way across the board. I think this is an absolute necessity.

And I think that it's important that it be unified for another reason also. I think we'll get better quality attendants.

I think we should pay adequate salaries, and I think we should demand a better quality of person.

There are certainly other things to work on and accomplish. I'm going to work on them. That's all I can promise you.

# How to Coordinate Emergency Services

**MARTIN C. McMAHON**
**Battalion Chief**
**Baltimore City Fire Department**

My talk to you will be about ambulance service as we operate it in the City of Baltimore. I know all of you are hospital connected and related, and that everyone complains about the number of visits increasing as far as the emergency room is concerned. The same holds true for ambulance service throughout the state and quite possibly elsewhere in the nation.

I always like to start with comparisons. Baltimore was the first city anywhere to place its emergency ambulance service under the direction of the Fire Department. This happened in June of 1927. Five ambulances were placed in service, and made 5,000 runs during the first year. Fourteen ambulances were in service last year and made 51,620 runs. So, while the size of the fleet did not triple, our patient load has multiplied ten times.

We were established primarily for emergency work and all emergencies go to the closest hospital. Doing this kind of work involves regimenting people and was brought up by Dr. Robert Kennedy from the Trauma Committee of the College of Surgeons a long time ago relative to a particular incident we had at the stadium where 40 people were injured. Dr. Kennedy said, "Suppose they don't go where you send them, Mac?" I told him very plainly, and bluntly, that they better had.

This is the advantage of putting an ambulance service in a disciplined rules and regulations group. Many people inquire, should we put it here, should we put it here, or elsewhere. My leaning naturally would be towards fire departments, all of them paid. Baltimore County and Baltimore City have rules and regulations, and if these men do not comply they are brought before the Board of Fire Commissioners, or before the chief, on charges. So they know that they had better stay in line and do the job that is required of them. We have a well-disciplined group. My leaning is toward fire departments merely because in some locations they lean towards police departments who are regimented as far as law enforcement is concerned. Fire departments lean towards life saving and the care of the sick and injured, and this is the reason I say that a well disciplined, well trained fire department is so essential.

### Maryland Training

As far as our training is concerned, I'm not going to go into that, but I would like to tell you, insofar as the State of Maryland is concerned, if you're concerned, please don't be. Maryland, New Jersey, Virginia, and some of the other states on the Eastern Seaboard are well trained as to care of the injured. When you get into other places you may fall into the hands of the undertaker one way or another. But I am happy with the training that has been given to rescue, fire, and ambulance squads in the State of Maryland. The State of Maryland compares favorably with any other state, as far as training is concerned.

As far as the hospitals are concerned, I brag about the rapport between the fire department ambulance service of the City of Baltimore and the emergency rooms of all Baltimore hospitals. The people in the City of Baltimore are spoiled. They don't realize how fortunate they are to have these services. And as they go into other cities as close as Washington, Richmond, or Pittsburgh, they are less fortunate. The ambulances do not respond as quickly nor are the hospitals in a particular mood to accept patients from them.

I have no concern about fire department ambulance service or the emergency room of any hospital in the City of Baltimore. The hospitals admit all and there's no discussion as to ability to pay or anything else.

As to alerting hospital personnel in the event of major catastrophes, our particular policy on multiple disasters is to have the first ambulance into the hospital be able to give some information to the people in charge of the emergency room as to the possible size of the disaster and the number of patients they may expect, so that the hospitals can gear up in getting ready for multiple accidents and multiple incidents.

### Hospital Alerted

As far as the individual case is concerned, our ambulance crews think that the hospital should be alerted. We have an electronic board at our headquarters. Our ambulance dispatcher knows where every ambulance is and what number ambulance is going to what hospital.

This ambulance responds to a particular incident and calls the ambulance dispatcher saying, for example, "Ambulance No. Three from Belair Road to Hopkins Hospital," and is plugged in accordingly. For serious gunshot wounds, stabbings, or cardiac cases, we have a hot-line connection within our headquarters and a call dispatcher at each hospital emergency room in the city. When this ambulance calls in the code is "alert the hospital." We have a call director. No dialing is necessary. There's a direct line from our call director to each one of these emergency rooms. The dispatcher picks up the phone and presses a button; a red light flashes and a bell rings in the emergency room. A doctor or nurse answers and these people are told of the case. I am on two-way radio call. I look at my watch and within 15 seconds after the ambulance crew calls, headquarters calls back and reports that the hospital has been notified. We do have a good communications hookup. The communications setup is the weak link in all disasters, but I think we have this pretty well licked as far as City of Baltimore ambulance service is concerned and with the hospitals.

### Mobile Hospital Unit

We have a mobile hospital unit which we dispatch to the scene if it is a multiple incident. It acts as a triage center at that particular disaster or in the event of single accidents where a person is trapped, for example, between an elevator car and a shaft. This person has to be sedated, or amputated. This is not a job for quasi-military or paramedical personnel. We have evolved an emergency squad doctor plan. Four hospitals cooperate: Hopkins, City, Sinai, and University. They send a resident in surgery to the scene either by police car or additional ambulance. He needs nothing but his knowledge. The mobile hospital unit carries all equipment necessary for amputation or sedation. When we cut this man out — I mean by that the floors and so forth have to be cut away with saws . This doctor and the patient are taken back to the hospital from which he came. In these cases, we do not go to the closest hospital.

As far as backup is concerned, we have worked on a number of cases with the surrounding counties (Baltimore, Anne Arundel, and Harford) when backups are needed. And we have a mutual aid understanding with these people in the event we need additional ambulances in the City of Baltimore. If they need help, they call us and we respond to back them up.

Dr. Cowley will report on utilization of the State Police helicopter. But I would like to add one aside. Recently there was a hit-and-run case at Northern Parkway near Hillen. Two State Police cars were enroute for transfer and were first on the scene. They immediately called for their police helicopter which landed on Northern Parkway. As our ambulance came out of Hillen into Northern Parkway, the police had already bandaged one patient. We took this patient by wheeled vehicle to St. Joseph Hospital. And the police helicopter picked up another from Northern Parkway and took her to University Trauma Center. So we do have a working agreement with the State Police that in the event of major catastrophes on limited access highways where wheeled vehicles have difficulty getting in, the State Police will assist.

### Future Developments

As to the future, a lot of people talk about radio hookups between all the hospitals and all the emergency ambulance services. This is elementary as far as cardiac cases are concerned. Some of these things may be possible. As has been indicated, certain funds are available under the Department of Transportation and National Highway Act. I availed myself of $60,000 last year and $90,000 this year to upgrade and improve the ambulance service as far as actual vehicles, and equipment are concerned. I'm not going to get involved as far as communications is concerned. But there are funds available that can be utilized if some people care to get into the communications setup. I think somebody, or a committee working with hospitals or fire departments, could work this out.

You probably read not too long ago there were thoughts about curtailing or doing away with the ambulance services of the City of Baltimore. Dr. De Hoff chaired a meeting where this received considerable discussion. You may have read the article about the Jacksonville Fire Department ambulance service. Their Captain John Waters said they'd rather do away with City Hall than with the ambulance service. I think the same feeling now exists in the City of Baltimore.

# EMERGENCY SERVICE TEACHING IN A COMMUNITY HOSPITAL

JOSEPH I. BERMAN, MD
Chief, Community Medicine
Sinai Hospital of Baltimore, Inc.



**Teaching, for many reasons, is not a word usually associated with emergency service activities, whether it be the emergency service of a large university hospital or a large community hospital, like Sinai. Most physicians, particularly those who have trained during the last 15 years when the emergency service crisis has become very acute, recall their period in the emergency room as times filled with a great deal of activity; so much activity, in fact, that there often "wasn't any time for teaching." Everyone was simply too busy to either teach or to learn anything. The rule of thumb often was "see one, do one, teach one." Luckily, we do not use this rule in other activities such as flying airplanes or driving automobiles.**

Besides the problem of no time, another reason why teaching has not been of major importance in the emergency service is the belief, most often expressed by specialists, that the emergency service really isn't a very good place to learn because of the rather confused nature of many of the problems brought there. The patient's problem is frequently not clearly defined even to him. In order to completely understand the patient and his difficulties, the emergency service physician may have to deal with a variety of specialty areas. The emergency service most often requires the services of a "doctor" rather than a "specialist." There are, quite often, social and psychiatric problems intermixed with the medical and surgical problems. Sometimes the social and psychiatric problems are the problems. The specialist decides the problems may be a little too confused for him to be involved, and compromises by sending the intern who doesn't know enough to be confused.

A third reason why teaching is not a word usually heard around emergency services is that no one wants to take responsibility for the teaching or for the emergency service itself for that matter. The responsibility for special units such as the Coronary Care Unit, or the Intensive Care Unit, is usually quite clear. The responsibility for the running of the emergency service, and the teaching there, is very often left quite unclear. Because there is no one to speak for the unit, the area tends to be ignored.

The result of this lack of concern about teaching has many serious effects on the ability of the emergency service physicians, particularly if they are house staff, to perform adequately. Physicians, being mortal, occasionally make mistakes and the pressures of a busy emergency service are very conducive to this. Because the physician rarely knows his patient, usually seeing him for the first time, he does not have the advantage of a previous examination.

Unlike the office situation where the patient usually comes back for follow-up, the emergency service patient is rarely called back. Thus, the emergency service physician does not have the great learning experience of the follow-up visit. Unfortunately, if the patient does not come back,

it could be because he is either too weak to return or, perhaps, dead.

In preparing this brief paper, I went to the hospital library and looked over what had been written about education in the emergency service during the past four years. I found one article entitled "An Emergency Department Teaching Program,"[1] describing the use of the emergency service for teaching fourth year students and house staff at the University of Rochester Medical School. I was unable to find any other articles which, at least through their titles, seemed to address themselves to the problem of teaching in the emergency service. This may well be indicative of the way medicine has looked upon the emergency service as a teaching vehicle up to the present.

### Emergency Service Staffing at Sinai Hospital

The basic purpose of my discussion is to try to demonstrate to you how we at Sinai have tried to adapt our own—perhaps rather peculiar—emergency service system, so that it can provide both the large amounts of service required, while also providing ongoing teaching and review of work done by house staff and attendings. Our staffing pattern includes the use of house staff, fee-for-service surgeons, and internists paid by the hour by the hospital.

The hospital has a very large and busy emergency service. This year we will have just under 70,000 visits, not including daytime pediatric walk-in cases which are included as emergency service visits in many hospitals. Staffing the emergency service at any given time are a first year resident in surgery, a first year and a second year resident in medicine, and an intern in medicine.

Pediatric house staff, usually an intern and a resident, are also assigned to emergency service work but these men spend the majority of their day and evening in the pediatric clinic which is open until 10:00 PM. There usually is one surgical attending physician in the emergency service afternoons and evenings, and sometimes in the morning. He is on call at night. He is available for those patients having no physician and who wish a private surgeon to care for them. He is also there to assist and teach the surgical resident as the situation demands.

A medical attending is usually on duty from 8:00 AM to 10:00 PM every day in the Outpatient Department, seeing a large percentage of those emergency service patients who were determined not to be acutely ill, by a triage nurse.

House staff and attending level physicians are available for consultation, day and night, in essentially all medical and surgical subspecialties.

In 1967 Sinai Hospital created the Department of Community Medicine. Part of the responsibility of this department was the emergency service, both medically and administratively. What I will describe to you are the efforts of this department in helping the patient through education of the medical staff.

### Teaching Care of The In-Bed Patient

The Sinai emergency service has an 11-bed holding unit, a remarkable, infinitely expandable area which has held as many as 27 people at one time. It is used as an accessory intensive care unit, accessory coronary care unit, and as a general overflow basin for the hospital when there are no beds available. Like most emergency services, it is also considered to be an alcoholic detoxification center and, on occasion, a nursing home. This area is frequently used as an observation or short-term treatment area by both attending physicians and house staff.

Daily, at approximately 8:00 AM, a member of my department makes rounds on all the patients in the emergency service, together with the house staff who have been covering the night before, and the house staff coming on duty. All patients in the emergency service are seen — service, private, surgical, medical, OB-Gyn, everyone. Each patient present in this holding unit is presented by a member of the night house staff, reviewed, and discussed. We attempt to teach in several areas that I feel are particularly pertinent to patient management in an emergency service, but are probably just as pertinent to patient management anywhere.

1) We ask: "why did the patient come?" Sometimes we find that that the reason isn't clear. Perhaps the attending who sent the private patient to the emergency service didn't communicate it well to the house officer, or perhaps the inexperienced house officer himself didn't really totally understand the patient's problems, and put the patient back into the emergency service in a bed, because he wanted time to think the problem through.

2) We then ask for the diagnosis. Frequently the diagnosis is not formulated. There will be comments such as "keep the patient for observation" or "chest pain."

3) We ask for a plan of care. "What kind of drugs are being given?" "For what purpose?"

"What therapeutic options are open?" "Does the plan of care include any major social problems which might affect the patient's outcome?"

4) We ask for disposition plans. "Should the patient be kept in the emergency service for a longer period? Should the patient be admitted to the hospital? Is nursing home placement most suitable?" A very difficult question to answer often is the question of follow-up care after the patient leaves the emergency service for his home.

This list of questions, of course, is really basic to the care of any patient. In the emergency service, however, the problem is a particularly acute one. Physicians are constantly changing. The patient, if he is there more than few hours, is bound to be cared for by more than one doctor. The MD coming on must understand what the MD leaving was attempting to accomplish. There must be someone responsible for the patient at all times.

5) Attempts are made, of course, to teach as much about basic disease processes as possible. This can be very tricky. The specialist, when making rounds, is usually presented with cases dealing with his specialty. Here, however, cases are being reviewed from every specialty and the physician must have a broad understanding and appreciation of medical and surgical problems in general.

What makes this particularly difficult is the rather resistant attitude that many physicians have towards even looking at patients who belong to some other specialty. It is not at all uncommon for a medical house officer to point to a patient in a bed and state, "Oh well, that's just a surgical patient." What the house officer means is that he really doesn't want to get involved with a patient who has problems outside of his particular discipline.

After formal morning rounds I, and the physicians who work with me, walk through the emergency service at least several times throughout the day, looking at the patients, talking to the nurses, and asking generally the same questions of the house officers that I have already mentioned. We expect that there will be a basic plan of care for every patient in the emergency service and this will include an idea of the appropriate and planned-for disposition.

What we are basically trying to teach, besides some facts about clinical disease, is a problem oriented approach. Determine what is wrong with your patient as quickly as you can and then determine what you want to do for the patient. This is something which physicians frequently seem ill-equipped to do.

### Teaching Care of Ambulatory Patients

As we are all aware, the nonacute patient is more frequently encountered than the acute patient in busy urban emergency services. These patients come with backaches, colds, chest pain, upset stomachs, and the like. Teaching the management of these patients, who really represent what the busy general physician would see in his office, is a particularly troublesome task. These patients come to the emergency service all day and all night, and it is impossible to review all of them while they are actually in the emergency service. Accordingly, we take a daily sample of such patients and utilize what we call the "lovenote" technique.

One of my staff reviews the chart and, on the basis of what is written in the chart, a brief critique is prepared. This is then given to the physician involved, together with a xeroxed copy of the emergency service chart. If a resident is involved, another copy is mailed to the chief resident of that service.

The critiques involve themselves with basic medical care, with the inappropriate use of diagnostic facilities, with proper referrals, and the like. They are very wide ranging, and have caused some interesting reactions from members of both the attending and house staff. No physician who receives this note must reply and we have found that most do not. Occasionally, physicians will become angry and challenge the points made on the critique. Not infrequently, after discussion, we find that the physician handled the case quite appropriately and either our critique was incorrect or the physician did not completely write down what he had done. House staff will, on occasion, send articles to us rebutting points that we have made. In many ways the approach has been as much of a learning opportunity for members of the Department of Community Medicine as it has been for those receiving these critiques.

### The Saturday Morning Conference

Another method of teaching used is something which I participated in at Baltimore City Hospitals when I was a house officer there, and Julius Krevans, MD, was the chief. This is the Saturday morning conference.

Every few weeks, before Saturday morning work rounds, the emergency service staff is called

together and a particularly interesting case is reviewed. If appropriate, a consultant is called in to help with the discussion. The house officers involved are called upon to explain and discuss what they did. Nurses also frequently participate in these conferences. The conferences are very informal and certainly nonpunitive.

One point that is constantly stressed is the need to document what has been done. Over and over, as charts are reviewed, it becomes clear that the physicians in the emergency service did a great deal more than had actually been written down on the chart, and the need for proper documentation becomes clear to all participating in the conference.

### Teaching by Non-Community Medicine Staff

It must be pointed out that there is a great deal of teaching being done in the emergency service that it not directly related to the efforts of my department. The attending surgeon, for instance, in the emergency room, also teaches on an ongoing basis and is always available for consultation to house staff. The amount of teaching done varies according to the number of patients waiting to be seen and the surgeon himself. Many other attending men from the Sinai staff come to see their patients in the Sinai emergency service, and frequently teaching is done by these men, also. Many of these individuals are members of the faculties of the two local medical schools. The medical attending working in the OPD is also available for consultation as needed. Lastly, residents from all the other services are constantly passing through the emergency service, contributing to the education of those assigned there.

Despite the invaluable efforts of all of these people, the difficulty is that this kind of input is very erratic—it depends upon the degree of business of these various physicians. There is also, occasionally, a reluctance of one private physician to become involved with the patient of another physician. This is why in every emergency service a distinct group of individuals must be designated to be responsible for continuous review of work done in the emergency service and education of the staff there. The task is simply too important to be left to chance.

### General Comments

When planning for emergency service staffing is being done, the need for ongoing education and the review of work must not be ignored. While it is reasonable and proper to worry about salaries, hours, and the number of physicians available, we must be sure that adequate attention is paid to whether the work being done in the emergency service is being reviewed, and whether the physicians in the emergency service are involved in an ongoing educational experience. This is particularly true when house staff physicians are being used in the emergency service.

We must assume that the teaching of physicians and review of physicians' work will improve the quality of medical care delivered in emergency services. Despite the fact that documentation of the value and effectiveness of our attempts to teach and review work in the emergency service is extremely difficult. Occasionally, we have been able to directly influence the handling of the patient in the emergency service and, thus, we know that we have been helpful. More frequently, the patient has already left and we can only hope that the physician has gained by our review. We assume that teaching does help the patient. That is the primary reason why we teach.

### Summary

The emergency service at Sinai Hospital has a very complicated system of emergency service coverage, involving both house staff and attending physicians—some of the latter being paid by the hospital, others working on a fee-for-service basis. In an effort to maintain high-quality care, the Department of Community Medicine was given overall responsibility for the conduct of the emergency service.

Through daily rounds and frequent visits to the emergency service, through review of a percentage of emergency service sheets (with subsequent written critiques), and through Saturday morning meetings where cases are reviewed with house staff, teaching is done in order to help the patient.

While it is difficult to quantitatively assess the effect of such teaching, we feel that this work benefits our patients sufficiently to warrant continuation of our efforts.

I feel strongly that every emergency service, no matter what its size and staffing pattern, must make provision for ongoing teaching and peer review in order to insure that patient care is kept at a high level.

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# Practicality of a Fully Private Staff

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**St. Agnes Hospital, Baltimore**
**Member, Emergency Physicians Services**

*(Read for Dr. Bianco by Mr. Robert Bartholomew, Assistant Administrator, St. Agnes Hospital.)*

**On December 17, 1970 in the *New England Journal of Medicine,* a special article entitled "Role of the Emergency Unit in a Community Hospital" made the following statement:**

**"Emergency room visits in the United States increased from 18 million in 1958 to 44 million in 1968. Most community hospitals have thus far responded inadequately to this demand in terms of space, equipment, and professional staffing. The community hospital emergency unit must more completely fulfill its role of an effective around-the-clock medical facility. There is a growing need for full-time emergency physicians with specialized training for this role."**

The statement that most community hospitals have thus far responded inadequately to patient demand in terms of space, equipment, and professional staffing, is misleading. Through the mechanism of default, society has demanded that hospitals provide 24-hour medical care in emergency rooms, despite the fact that many hospitals are unable to meet this demand because of lack of space, lack of staff, and lack of money. One might make a case that such a demand is unjust and that society, including physicians, has done little to assist hospitals in coping with the emergency room deluge. Further, 50% of patients who frequent emergency rooms do not require emergency room services.

Society cannot demand these services from individual physicians because they are already overworked, lacking in numbers, and oftentimes reluctant to volunteer or participate in rendering emergency room care to the community. In many cases this reluctance is reasonable, because certain specialties do not lend themselves to the demands of emergency room medicine. Physicians who limit themselves exclusively to narrow areas of medicine might encounter situations for which they are totally unprepared, and thus make them feel insecure and fearful of malpractice suits. It is unlikely that society can demand that physicians as individuals provide 24-hour ambulatory care. The patient who frequents emergency rooms wants more than just a qualified physician. He wants the allied health personnel, the X-ray, laboratory facilities, and the sophisticated hardware the patient thinks he needs.

The hospital (the term "hospital" used in this paper means board of trustees, administration, and medical staff) is the logical place to meet societal demands for 24-hour emergency room care. Why? In recent years there has been a cymbal-clashing movement by the American Hospital Association, the Catholic Hospital Association, and the Public Health Service that the hospital is where comprehensive health care can be best developed and delivered. On the surface, this seems logical. The hospital contains the hardware, is organized and experienced in management, has personnel, and has a medical staff. Hospitals are under continuous surveillance by health commissions and licensing agencies such as the Joint Commission on Accreditation of Hospitals, state and city health departments, Medicare, Medicaid, and third-party insurance carriers. Hospitals are required to meet standards of all of these accrediting bodies, albeit at times their standards conflict. Each accrediting body demands emergency room services, outpatient

services, and encourages involvement in community needs. There is little doubt that hospitals have demonstrated a willingness to accept responsibility to provide 24-hour emergency room care. The adequacy of the response by each hospital depends on the community and its willingness to share in the responsibility through moral and financial support and, most important of all, qualified professional staffing.

### Private Staff

The question is "what is the practicality of a fully private staff?" Is it a permanent solution or rather is it a transitional development toward better staffing patterns?

Historically, until 1966 the emergency room at St. Agnes Hospital was staffed by interns. Consultation was rendered to the interns by the resident physician staff. In the tradition of American medicine prior to the 1960s, the most complex medical care system in the hospital was charged to the least experienced professionals. Traditionally, teaching hospitals rendered community care by utilizing intern and resident physicians. On occasion, depending on situations, there was a varying degree of supervision of these individuals by attending physicians. It was a noble and kindly gesture to the poverty stricken community, but one can hardly make a case that this kind of medical care approached the level of care rendered by the private practicing community. In the early 1960s residency review boards developed increasing demands, and justly so, for the proper organization of residency teaching programs which were to be judged primarily by their educational value, rather than by the traditional standards of the medical staff. The residency review boards further pointed out that once the outpatient and emergency departments became primarily a service obligation to the community, without supervision and education, probation or disapproval of that particular residency program would follow. At that time the Board of Trustees at St. Agnes Hospital elected to continue as a community teaching hospital, and made a commitment to develop residency programs that were in keeping with the standards of the residency review boards. In 1966, therefore, St. Agnes embarked on a series of staffing patterns for the emergency room which presently is an incorporated and fully private staff.

The first attempt at staffing the emergency room was through an enforced voluntary rotation mechanism of the entire attending staff. This was reluctantly accepted and happily rejected after three months.

### Old System Scrapped

This system was scrapped for the following reasons:

1) The mandatory system to render medical care was repugnant to a number of seasoned attending physicians because they felt they have been through the "hazing" period of staff membership, ie, clinics, service cases, etc.

2) Many patients—particularly those gainfully employed and with insurance—were not being charged a professional fee for services rendered. Governmental agencies were not being charged for care of the medically indigent.

3) Physicians who were involved in very superspecialties were rather uncomfortable in the emergency room environment because they lacked broad spectrum medical knowledge, and some feared that their specialty image might "tarnish."

4) There was a fear by many medical staff members that their liability coverage did not include emergency room medicine.

The next emergency room staffing pattern was instituted in 1967 and was known as "Moonlight Bay" for interns, residents, government physicians, and young physicians—as a matter of fact, any physician who wanted a job. Eighty percent of the staffing pattern was covered by interns and residents, most of whom were unlicensed; some were not of the St. Agnes House Staff. This system provided 24-hour coverage, and each physician member of this system was in essence an employee of the hospital. An inherent problem in this staffing pattern for the intern or resident was that he had to sacrifice time from his training program in order to provide emergency room coverage during the hours between 8:00 AM and 4:00 PM. On some occasions residents would combine their training obligation with covering the emergency room as a "moonlighter." The interesting point to note here is that, whereas in the past interns and residents were quite indignant about having to cover the emergency room above and beyond the requirement for education, (in other words, they were not in residency just to render service) it was no longer a problem to sacrifice time from the education program because the moonlight situation was on a remuneration basis.

### License Required

In July 1969 the Medical Practices Act of the State of Maryland made it clear that any physician engaged in the treatment of patients must have a license, unless he is functioning within an accredited training program. It placed the moonlight staffing pattern in jeopardy because the moonlighting nonlicensed physician was not, strictly speaking, functioning within a training program during his moonlight hours. There were those in the institution who said, "Let us find ways to make this emergency room coverage part of the training experience." Fortunately, reason prevailed. Trying to operate within legal loopholes of the Medical Practices Act seemed fraught with danger.

### Plan Developed

In September 1969 the board of trustees of St. Agnes Hospital directed the office of the medical director to plan and develop a system of emergency room staffing by licensed physicians—preferably practicing physicians who are members of the St. Agnes Hospital medical staff. This is a new twist by a board of trustees. They specifically state a preference for practicing licensed physicians to render care in the emergency room, rather than interns and residents outside of a training program. The board of trustees clearly states that it has an obligation to render care in keeping with the spirit of the Medical Practices Act, and further recognizes that practicing physicians are more experienced and are expected to render medical care that is based on local and national standards.

At that time the question was not, "What is the practicality of a fully private staff?" but rather, "What practical system could be devised that would: 1) render the best possible medical care, 2) attract experienced licensed physicians to render care in the emergency room, 3) be acceptable to the medical staff, 4) be acceptable to the board of trustees, and 5) be acceptable to patients?"

A fully licensed "moonlighting" resident staffing pattern was considered. This concept was quickly dismissed because the criteria of experience was usually lacking, and there were not enough licensed residents available. One would still have to face the problem of removing the resident from his training program in order to cover the emergency room.

A group of hired full-time physicians was considered. This was dismissed because of a number of concerns expressed by the medical staff for such a system, and there was a reluctance to grant privileges to just anyone to work in the emergency room. Some physicians feared that a full-time emergency room staff could readily become self serving, and disregard traditional patient-doctor relationships.

### Present Plan Favored

The present plan (modeled after the Pontiac Plan in Michigan) had the least resistance. The present staffing pattern is comprised of a corporation of 25 practicing physicians who are members of the St. Agnes Hospital medical staff. The physicians are incorporated according to the laws of the State of Maryland. Membership was available to any member of the medical staff and continues to be, provided shifts are available. The physician corporation has an agreement with the hospital to provide coverage of the emergency room 24 hours a day, seven days a week. The corporation is accountable to the board of trustees, through the medical staff, for its performance. The hospital grants the corporation a franchise to render care in the emergency room on a fee-for-service basis. The corporation must show evidence of quality care, peer review, continuing education, and proper organization. The hospital in turn would provide adequate space, personnel, and equipment.

### Emergency Room Challenge

Why should a practicing physician want to work eight to 16 hours per week in an emergency room when he is already busy enough in his private practice? Emergency room medicine is physically and emotionally stressful. Patients are demanding and sometimes nasty. The hostility of patients toward the hospital emergency room seems misdirected, particularly when one realizes that the hospital is providing emergency room services 24 hours per day. Perhaps the patient should direct his hostility toward his personal physician who is either unavailable, or referred the patient to the emergency room rather than appear himself. Despite stress and patient hostility, some physicians find the challenge of emergency room medicine rewarding—one does things and can see results often enough to make the experience gratifying.

Some physicians are looking for ways to phase out solo practice, which they find too demanding, and are looking toward the emergency room as a possible vocation. Further, the emergency room

experience is an educational system that can prepare one for full-time emergency room work. The eight to 16 hours per week emergency room experience provides the practicing physician an opportunity to experience another kind of medicine without giving up his private practice security. Most of the physicians in the group find the fringe benefits an incentive to participate in part-time emergency room care. There is adequate compensation without overhead, insurance programs (disability and liability), corporation benefits for tax free shelter, investments, pension plans, and life insurance.

### Two Common Objections

What are the objections to a physician corporation in the emergency room, or the practicality of a fully private staff? Let me attempt to answer two common objections.

**Objection #1:** A private corporation will become too autonomous. The temptation to "steal" patients and utilize arbitrary choice of consultants is inevitable. The corporation will feed patients to its own members.

This objection is readily overcome by medical staff policy on referrals, and consultation which prevents the corporation from internal patient feeding; the hospital and corporation must enter into an agreement that specifies the functions of the emergency room group. At St. Agnes Hospital, each member of the physician corporation, while in the emergency room, acts only as a primary treating physician. He initiates primary diagnostic and therapeutic measures. The physician corporation utilizes consultants according to patient need, and as directed by each clinical department. To my knowledge, there has been little, if any, difficulty in patient referral.

**Objection #2:** What guarantees does the community have that the emergency room physicians are adequately trained for emergency room medicine?

First, a physician who elects to render emergency room care is confident that he has the skill and ability to progress as an emergency room physician. The medical staff must insist on proper medical audit procedures, continuing medical education programs, and surveillance by the executive committee. Further, the practicing physician brings with him experience in dealing with a wide variety of patients. This experience gives the physician a sense of urgency, and an ability to deal with emergent situations. The St. Agnes Hospital staffing pattern provides cross-fertilization of medical knowledge because surgeons, internists, and general practitioners exchange specialized diagnostic and therapeutic know-how, on the scene.

Superspecialty consultants are much happier with the present system, because there is a peer relationship. The experienced physician can communicate freely with the consultant (because he is his peer); consequently, consultants respond readily to patient needs. As said so well by one of our superspecialists, "Before the emergency room group began to function, I was constantly besieged by telephone calls, and made numerous visits to the emergency room, which I found unnecessary. With the advent of attending staff physicians, the calls are much fewer and almost always timely, and when the physician requests my appearance I had better go because the situation almost always requires my presence."

### Epilogue

We have attempted to outline the evolution of emergency room staffing patterns at St. Agnes Hospital. The present staffing by attending physicians who are members of a corporation and who elect emergency room medicine as an avocation is a definite advance. These men are experienced, willing to make progress as physicians, and work well together in teams. Professionally they reinforce each other, have good relationships with the house staff, and do not hesitate to utilize consultative services in the best interests of patient care.

It is my opinion that the present system is but another transition toward improved staffing patterns. It seems reasonable that within two to five years the emergency room staffing pattern will be comprised of eight to 12 physicians who will devote their full time to emergency room medicine, and become emergency room specialists.

Until that time arrives, the present system is adequate, practical, and well accepted by both the medical staff and patients. As in all new specialties in medicine, until emergency room specialists and training programs are available, the physician community must fill the gap. In my opinion the Pontiac Plan, as used at St. Agnes Hospital, is an excellent transition measure, and indeed may prove to be quite adequate as a permanent measure.

# HOW TO MANAGE CRITICAL EMOTIONAL STATES 24 HOURS A DAY

## The Staff, Setting, and Coordination Needed to Make This Work

*A panel discussion during the Practical Emergency Department Symposium, sponsored by the Medical and Chirurgical Faculty of Maryland, at St. Joseph Hospital, Towson, Maryland, March 31, 1971. The speakers included these three doctors from The Sheppard and Enoch Pratt Hospital, Towson, Maryland:*

**ROBERT W. GIBSON, MD**
Medical Director
**KENT E. ROBINSON, MD**
Director, Outpatient Services
**ARTHUR M. HILDRETH, MD**
Assistant Director, Crisis Service

*(After introduction by the chairman of the Subcommittee on Emergency Medical Services of the Committee on Preventive Medicine, John B. De Hoff, MD, the panel was turned over to Dr. Gibson. He handled the introduction of speakers, the discussion, and the question-and-answer period that followed. We begin with Dr. Gibson.)*

## Dr. Gibson

I will begin by giving you an overview of the development and organization of emergency services at The Sheppard and Enoch Pratt Hospital. Dr. Kent Robinson will tell you about the specific problems that we have encountered in developing these services. Dr. Arthur Hildreth will describe the types of patients we handle and the treatment techniques.

The emergency service and crisis clinic must be looked upon as part of a bigger system of mental health services. In the past decade there has been an increasing emphasis on the development of comprehensive community mental health services. Prior to this time, most areas had a split system for providing psychiatric care. On the one hand were the inpatient services, which in terms of numbers of beds were primarily state hospitals. These were remote and removed from the community. On the other hand you had psychiatrists in private practice seeing people in their offices, but doing little outside of their consultation room. This left an enormous gap.

We now realize the need to have a continuum of care between these two. Comprehensive community mental health service emphasizes two key words: "comprehensive," which refers to the continuum of services at all levels to all people; and "community," which emphasizes that these services must be where the people are and readily accessible.

Emergency services in this scheme are extremely important. In your discussions you will probably emphasize the importance of direct services to a person who has an emergency condition. These may involve nonmedical people who usually do an extraordinarily good job. For example, the police, while they are more than willing to help, shouldn't have to make the decisions about whether a man is suicidal. They want to get the man into medical channels, and rightly so.

A second reason for the importance of a good emergency service is that it identifies the problem promptly. This gives a much better chance of getting the person started into the right track of care. This is more of a concern in psychiatry, than it is in other fields of medicine.

For example, it is important to avoid unnecessary hospitalization. If a man goes unnecessarily into a hospital you start a process, a chain of events. Of course, if this care is needed it should be done promptly because we want to get treatment started in the right direction.

Sometimes it is difficult to know who needs treatment. Suppose you have a situation of severe tension between husband and wife. The person who appears more upset might not be the

person who really has the more serious problem, so the crisis treatment may help decide who needs the treatment.

A third advantage of emergency services and crisis intervention in psychiatry is that the person in the crisis situation can frequently be helped more with certain problems than at a later time. The person who has had a problem for a long while but has resisted help may, at a period of crisis, be more open to taking a look at it. Thus you may accomplish more in that brief period than you could in months at a later time when they avoid and deny the problems.

In terms of the way that Maryland is going in community mental health, Governor Mandel and Secretary Solomon have repeatedly indicated a concern, even a commitment, to move in the direction of providing more community mental health services.

Any program that tries to change the system is going to go slowly and move with the availability of funds. It takes time to develop facilities and train personnel. Even though the progress today is not rapid, I hope in time that every person in the State of Maryland would have available the full range of services of a community mental health center. And an emergency service with a crisis clinic is a key component of the center. The other components are inpatient psychiatric services; a service called a partial hospitalization service. (This may be a program where the person goes in the day, sometimes in the evening); outpatient services; and a service that supplies consultative assistance to other community agencies and health professionals.

In Maryland, state funds are allocated for the community mental health center programs. Various hospitals, agencies, and health departments may make grant requests for these funds to develop specific mental health programs. These requests go to the county health officer; although the funds are state funds, administration is on a county basis by the county health officer.

The county health officer, assisted by an advisory group of citizens, studies each grant request to see that the proposal fits in with the overall plan of the state. They establish priorities, strive for orderly development, and try to avoid duplication.

After this review, the proposal goes on to the state level for further review. Ultimately, if the funds are made available, it comes back down in the same route.

I'll comment only briefly on the Sheppard-Pratt program because Dr. Robinson will say more about this. About a year ago we submitted a grant request to develop an emergency service and crisis clinic in collaboration with Greater Baltimore Medical Center and St. Joseph Hospital; this was part of a larger community mental health program. It was planned as the opening phase to a broader range of services.

That's enough background. Dr. Robinson will say more about the organization of our program. It's a practical example and may be of interest to those who may want to develop something of a similar nature.

# Dr. Robinson

The way we run our psychiatric emergency service is not the only way. But we didn't make it up all on our own. Dr. Blumenfield and I visited various similar services throughout the country to make site visits. We found that most successful emergency services are run somewhat after the model we are following.

Prior to our opening on June 1, 1970, there were no psychiatric emergency services as such for the whole of Baltimore County. This is not to say that people such as Dr. Riley at St. Joseph and his excellent staff were not taking neuropsychiatric emergencies. They certainly were. But if they wanted a consultation in the middle of the night on what they were doing, it was very difficult to obtain one.

We cover a specific area. The grant funds that Dr. Gibson talked about are given in exchange for covering a specific area. The area that we cover goes from the city line on the south to the Pennsylvania border on the north; on the west, it's Reisterstown Road; and on the east, it's Belair Road. This constitutes a considerable section of the northern part of the county. The other parts of the county are covered by facilities being developed by the Baltimore County Health Department's Mental Health Division.

Our goals were to provide around-the-clock coverage and supporting services such as a back-up clinic and crisis clinic, which it takes to provide the services.

One purpose of the emergency service, as we saw it, was to provide screening on all suicide attempts. The emergency rooms at St. Joseph and GBMC have, I think ever since they opened, been swamped with people making suicidal attempts or gestures and never really being sure whether to send them home or admit them to a state hospital. As Dr. Gibson said, sometimes the doctors feel that they really had no other options.

Furthermore, we wanted to provide screening of all patients with any kind of emergency emotional problems. The purpose was to make available to them or their families all of the options other than a state hospital. For example, there are some things you can do with patients other than send them home or to a state hospital. You can send them to a follow-up crisis clinic, to one of the outpatient clinics in the county, to a private therapist, or to a day hospital. To help locate these for a patient can be quite a service.

In many cases, patients have insurance which will pay for private hospitalization, but they don't even know that they have it. They may have major medical coverage that pays up to 80% of their bill in a private psychiatric hospital, again without knowing it.

I'll describe our service more specifically. We provide psychiatric consultation coverage to the emergency rooms at St. Joseph and GBMC 24 hours per day, seven days per week. A large percent of those coming to these two emergency rooms will be disposed of by the emergency room doctors. However, some cases will require a consultation. In that event, they call the crisis service at Sheppard-Pratt. And, at any hour of the day or night, we'll have somebody go over to see the patient, usually within half an hour at the most. This is good considering that if you try to get a psychiatric consultation in private practice some of you know that it sometimes takes a week or more to get somebody to see a patient for you.

### Crisis Clinic

I'd like to say something here about the back-up clinic, the crisis clinic. This is an essential part of the whole emergency service.

It's essential because most psychiatric emergencies can be resolved if a month's wait is not required to see a psychiatrist for therapy. If you can see the psychiatrist within half an hour or the next morning at a clinic and strike while the iron is hot, it has been found, on a national average, that about 80% of the kinds of things that used to wind up in the hospital can now be handled on an outpatient basis if they don't have to wait and can just go to a crisis intervention clinic.

This is what we are running at Sheppard-Pratt from 9:00 AM to 5:00 PM and from 6:00 PM to 9:00 PM Monday through Friday and from 9:00 AM to 12 Noon on Saturday and Sunday. These are clinic hours, although emergency room consultation service is a 24-hour thing.

Since we have no drugs, sutures, or stomach pumps at the clinic, if you refer somebody to our crisis service and if they are disturbed and in need of suturing or unconscious from an overdose, we obviously prefer that you send them to the emergency room so we can see them there. If, however, they're awake and just anxious and upset, during the hours that the clinic is open, we prefer that you send them to the crisis clinic because we have more staff there to handle them.

A few words about our staff would seem in order here. We have half of Dr. Blumenfeld's time. He's director of the crisis service. We have 60% of Dr. Hildreth's time. He's assistant director of crisis services. We have a full-time psychiatric social worker, a full-time mental health technician, and a secretary. And every night from 6:00 PM until 8:00 AM the following morning the service is covered by one of our psychiatric residents.

### Who Can Refer

Now, a word about who refers or who can refer. Of course, you doctors or nurses can. Patients can refer themselves; they can also be referred by their family, the clergy, or the police. Instead of taking patients who have obvious psychiatric emergencies to jail, as they used to have to do by law, the Baltimore County police now bring them to the emergency room where they will be seen by our psychiatrist and taken care of. This arrangement applies to our catchment area. It is one we are very proud of because, in the past, sick people were having to be taken to jail until a doctor could get to see them.

A few words about statistics are also in order. We've been open nine months. After a slow start, it's picking up to the point that we may be getting into a crisis of our own. We've seen about 650 new patients and had about 1,000 revisits. It's now up to over 200 visits per month.

And you should remember that a visit could mean half a day with a disturbed family. A visit is not looking at somebody's throat and seeing if it looks red. A visit can be brief at times. At other times, it can mean half a day's work, and that all gets counted. About one third of these people are seen in one of the other emergency rooms. The others are seen at our crisis clinic during clinic hours.

So, now I'd like to turn it over to Dr. Hildreth who will tell you something about the patients we have seen.

# Dr. Hildreth

I would first like to review generally what happens on a daily basis in the crisis clinic. We get referrals from numerous sources: police, St. Joseph and Greater Baltimore Medical Center emergency rooms, the various social service agencies, community physicians, and patients.

Essentially, we have two functions. One is to the emergency room and the other is providing acute psychiatric treatment.

In terms of consultations, the bulk are to the emergency rooms, to assist them in evaluating acute situations. Often, the major questions involve whether someone has an organic brain syndrome or some sort of psychiatric disturbance.

If we can clearly determine to the requesting physician's satisfaction and to ours that it is a psychiatric disturbance, then our next problem is to define the situation as clearly as we can and try to see whether hospitalization is indicated or not indicated. If hospitalization is needed, then we can be of some help in effecting it.

If hospitalization is not indicated, and patients will agree, we then refer them for acute psychiatric treatment in the crisis clinic. This consists of a maximum of six visits which can be spaced out anyway that we find to be most useful. They can be six visits in a row in one week; three visits one week, two the next, and one the following week; in fact, anyway that we feel to be most appropriate to help a person resolve the acute difficulty and to help him see what he can do.

We picked six visits because it's the common number that other clinics use, but we don't necessarily hold the line in that regard. From a practical standpoint, if a person has an acute problem, often he doesn't need more than six visits to help figure out what he wants to do about it.

One additional facility which we have available at GBMC, in addition to outpatient treatment and consultation services, is the option to admit someone to the emergency room overnight. If the person is acutely psychotic and we feel that the night's stay, plus medication, would help resolve some aspects of the acute difficulty, we have the option to admit him. We can review things the next day to see if we can let him go for outpatient treatment or if he needs to be hospitalized for inpatient treatment.

Secondly, I will give you three examples that we see as illustrations of our general approach.

Last fall, one of the county clinics referred a 25-year-old man who walked in quite anxious and very suspicious. He was very afraid of shooting his employer with a gun and was quite concerned over these sudden and frightening impulses.

He came in with his wife and we saw the two of them. We try to involve the family as much as we can because, if somebody is in an acute situation, we often don't get as complete a picture from a particular individual as we do from the family. Also, when a person presents himself as being acutely disturbed, this disturbance is a reflection of a more general disturbance in the family. So, from the standpoint of getting the information and of knowing what to do about the situation once we get it, we often try to see the families. That's an aside, however, and I'll continue with our 25-year-old man.

He was quite anxious. On mental status examination, he did not appear to have any acute brain syndrome or any organic disturbance. He told me that he found himself furious at his employer. He had been working there for about three years and had been quite anxious to succeed because he had difficulty on previous jobs. He had noticed illicit and minor pilfering. He was so anxious to please his foreman that he kept going up and reporting it. The foreman kept telling him to forget it, that it wasn't worth his while, that the pilfering was minor and was an unofficial custom of the company, that nobody cared that much about it, and that he ought to have enough sense to keep his mouth shut about it. On the final episode, when his foreman became furious at him, he went home and started to ruminate about killing him.

On talking to him further, I learned this had some pertinence to his past history and a life style of trying to perpetually please his parents but never succeeding and never being able to express any open anger at his parents, particularly his father. This appeared to be the last straw in a series of disappointments. This helped us understand the degree of emotion he had at this time. In addition to this understanding, we had to make sure that this fellow didn't become grossly psychotic or kill his employer.

After speaking to him and his wife, we found that he had no history of any violence. We evaluated him as clearly as we could for a history that would indicate that there was a potential for violence. As far as we could tell, it wasn't there. The only thing which we did know was that he was a good shot and that he had a lot of rifles in his house.

We saw him daily, told his wife to get the guns out of the house, and put him on trifluoperazine hydrochloride (Stelazine), one of the major tranquilizing medications, in hopes that this would allay his suspiciousness and anxiety.

Within four sessions, he was remarkably better. It was pointed out to him that he didn't need to please his foreman in the way that he was doing it, that perhaps a good job would do just as well. This relieved him a great deal, and within a week he was able to return to his job.

At the end of the fourth session, we asked him what he wanted out of further treatment; he wasn't quite sure. Because he had a tenuous tolerance to stress, we felt that further psychotherapy of an exploratory type wouldn't be particularly useful to him, but that he should be continued on medication for about a six-month period in hopes this would decrease his anxiety and continue to decrease it so that he could resume his job.

He was referred back to the original county clinic. We requested that he be followed up once every three weeks or every month for medication. Additionally, he was urged to return to our clinic if he felt at all anxious, or if the clinic that referred him became concerned about him. He agreed to do this, and, as far as I know, things worked out reasonably well.

There are two points here. One is that I think this man avoided hospitalization by coming in very quickly. He also avoided potential mayhem and murder. I think, in addition, it was essential to have the wife there to get important information about guns in the house, general behavior, past behavior, and behavior at home, in addition to the job. We could tell that most of this difficulty was fairly well isolated to the job and that the home problems didn't appear to be overwhelming in nature.

### Second Example

The second example is a 23-year-old woman who was referred to us from Johns Hopkins Hospital. She had been admitted (They have a similar emergency room service.) after making a significant suicide attempt. The physicians there asked if we could see her. Most of this had to do with the fact that she lived in our catchment area, plus the fact that she knew some Hopkins physicians. After talking to them, it was felt that it might be less complicated to have us see her rather than to have her seen there, although I think it could have worked out either way.

When I saw her, she was quite depressed, had been smoking a great deal of pot, had been rejected by a boy friend, and was quite disturbed over this. As in the previous case, this appeared to be repetitive of repeated rejections from both her family and previous boy friends.

She was quite tearful, profoundly depressed, and had suicidal thoughts. I recommended hospitalization, but she rejected it. Her family lived out of the state. I was hesitant to hospitalize her without her family's knowledge and permission. I called the family and they agreed to come to Baltimore. Her roommate accompanied her on her return to the clinic that night.

I saw the patient and her mother the next day. Again, I felt it was essential to have the family involved, whether she was living with them or not, so that they would know what was going on. Also, they could give necessary information.

She again refused hospitalization. Her mother also refused it for her. The two of them became incensed at me for suggesting it. It seemed to me that what had happened was that the original rage at the boy friend, which precipitated the depressive episode, was directed at me and at the crisis clinic.

With some reservations, I referred her to a few outpatient therapists who were willing to see her and evaluate her to see if she was able to work in outpatient treatment. She saw one of them 48 hours later and got into outpatient treatment. According to all reports, she has been doing quite well. There has been no more pot, no more depressed episodes. I'm not sure what this means for the long-term future, but I do think that quick contact and referral helped to avert hospitalization.

### Third Case

The third case, which didn't avoid hospitalization, was that of a 14-year-old youth who came in after attempting suicide. After two sessions, it appeared that his suicide attempt, his antisocial behavior of stealing, and his getting into furious fights with his parents was an unconscious attempt to divert parental fights. They were covertly furious at each other, and his antisocial behavior tended to divert their activity from each other and to focus on this young man.

When this was brought out in family sessions, the mother became profoundly depressed, the family became quite disturbed, and they stated that the boy had to leave the family and be hospitalized. He became even more depressed. It was felt that hospitalization was indicated because of family turmoil and because of his de-

pression. We were able to give the referring hospital considerable information about the difficulties. As of now, we have no follow-up on him.

I have described our clinic operation and I've given three examples to show what is done and how we work.

*(At this point, the meeting was returned to Dr. Gibson who conducted the question-and-answer period.)*

*Dr. Gibson*: In preparing this presentation, we thought we would try to cover a range, realizing that there may be a number of specific questions. We will be glad to respond to any questions.

*A Doctor*: Have you had any sizable number of patients coming to you with the problem of drug abuse as the primary problem? Some feel there is always an associated problem, but is that a primary problem that you see very much of?

*Dr. Hildreth*: Well, it has been something on which we've had sporadic referrals. Unfortunately, there's not much that we can do about it. For one thing, the acute problem is withdrawal, and once that has been settled you are confronted with a rather long-term problem. Thus, although it appears acute on the surface, it often is not. So there's not much to be done other than to refer to appropriate community facilities for long-term treatment, such as they are.

*Another Doctor*: I'd like to ask how the catchment area for the program was determined.

*Dr. Gibson*: This was determined in general as part of an overall state plan several years ago. First, a total state plan was drawn up and efforts were made to group these to establish catchment areas on a logical basis. The counties and the local people have done some reworking of those, but there are several things taken into consideration.

You don't want to be too large. You wouldn't want it to go over 200,000; it's probably better to have it even less than that. You don't want it to be too small, because if it's too small it's not large enough to support certain types of facilities. You try to relate it to existing transportation. You try to relate it to certain natural boundaries or attitudes that people have about where they are apt to go for services. There may be dozens of factors taken into account to make what would just seem to be the most logical functional unit. We did not ascertain this; it had already been determined.


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*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

rehabilitation medicine

# "BELL'S" PALSY

**JOHN E. GESSNER, MD**
**Associate Professor**
**Dept. of Rehabilitation Medicine**
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**School of Medicine**
**Baltimore**

According to J. A. Hilger,[1] Bell did not describe the palsy to which his name is attached. Hilger stated that, in spite of all of the theories on etiology, the cause is unknown. At the present time Hilger is still correct. He thought the cause to be the result of local vascular changes in the nerve, and recommended vasodilator drugs along with surgical decompression to relieve secondary edema which caused pressure on the nerve. Ballance and Duell[2] had described an operative decompression technique as early as 1932.

The big problem with surgical decompression is who should get it. The field was considerably narrowed when Hilger and others brought attention to the electro-physiologic responses of the seventh nerve. Mathog and Hudson[3] point out that by means of nerve excitability tests and electromyography, prognostic categories for Bell's palsy can be outlined. In simple neurapraxia, where the affected nerve can be stimulated with nearly the same amount of current as the normal side, and where electromyography never demonstrates fibrillations, the paralysis will remit completely in eight weeks or less. This is important, since in a recent study[4] of 242 cases of Bell's palsy, only 14% showed signs of denervation. With complete reaction of degeneration, where the nerve will not respond to electrical stimulation at all, prognosis is poor, with considerable facial weakness and synkinesis (involuntary associated movements) developing.

A third category is called incomplete or partial degeneration. Here some fibers have degenerated, others are in a state of neurapraxia. Nerve excitation requires increased current, latency is prolonged, and fibrillation is seen. Mathog and Hudson had only one such patient in their series. My experience with these patients has been that synkinesis and weakness are common. In the Mathog and Hudson series seven patients who showed complete degeneration of the facial nerve were given surgical decompression from six to thirteen weeks after onset of degeneration. In none of these patients was synkinesis prevented, and return of muscle strength was not complete. They conclude that late decompression "cannot reverse the process of degeneration." They state that "it is doubtful that vigorous therapy, after degeneration has occurred, can affect the outcome of the disease."

Adour and Swanson have recently reported on a series of 242 cases of Bell's palsy.[4] All patients were told to massage and exercise the facial muscles daily at home, and galvanic stimulation was not used. Sixty percent of the patients had an incomplete paralysis which had recovered considerably within one month. Thirty-four percent of the 40% remaining who had complete paralysis showed denervation. This group was randomized into three subgroups. Group one received no surgical treatment. Group two was given nerve decompression within 48 hours of the detection of impending denervation. Group three was given decompression eight to 12 weeks after onset of denervation "if there was no adequate return of facial function at that time."

Their conclusion was that "early or late facial nerve decompression is not of benefit in patients with Bell's palsy who show evidence of impending or actual denervation based on nerve excitability testing."

Other authors[5] have indicated that the incidence of synkinesis is reduced if decompression is done less than two days after onset of signs of

degeneration. Drug therapy has not altered the natural history of the condition as far as one can tell, although steroids are currently widely used.

One can only surmise from all this that there is no definitive treatment for Bell's palsy as yet. The best we can do is to make the diagnosis correctly, and in this regard to remember that facial paralysis is an otolaryngological entity. It will depend upon the clinical judgment of the surgeon as to whether or not exploration and decompression are indicated in facial paralysis. It is also possible to make a prognosis for early recovery by doing nerve excitability testing and electromyography during the first three or four weeks after onset. Those who show denervation will have variable amounts of weakness, and almost all will have synkinesis. From the clinical standpoint, partial paralysis, slow onset, and absence of pain are indicators of favorable prognosis.[5]

As to physical measures, for the majority of patients simple home massage and exercise will do. Those with neurapraxia will get better anyhow, and these represent more than half of all cases. If electrical stimulation of the paralyzed muscles is felt necessary, this can also be done at home by the patient seven days a week as often as desired with a small and inexpensive galvanic stimulator sold on prescription at surgical supply stores. Some hospitals rent these stimulators for very nominal fees making the cost of electrical stimulation negligible on a per-treatment basis. Heat modalities, other than a heating pad for the transient pain of the neuritis, are not indicated.

Although Bell's palsy is a distinct clinical entity, its etiology and treatment remain subjects for continued investigation. Surgical decompression, a currently popular technique, does not seem to offer the promise that it originally did. The course of the disease can often be predicted by electrical testing early after onset. Fortunately, even in most untreated cases, the prognosis for good return of function is favorable.

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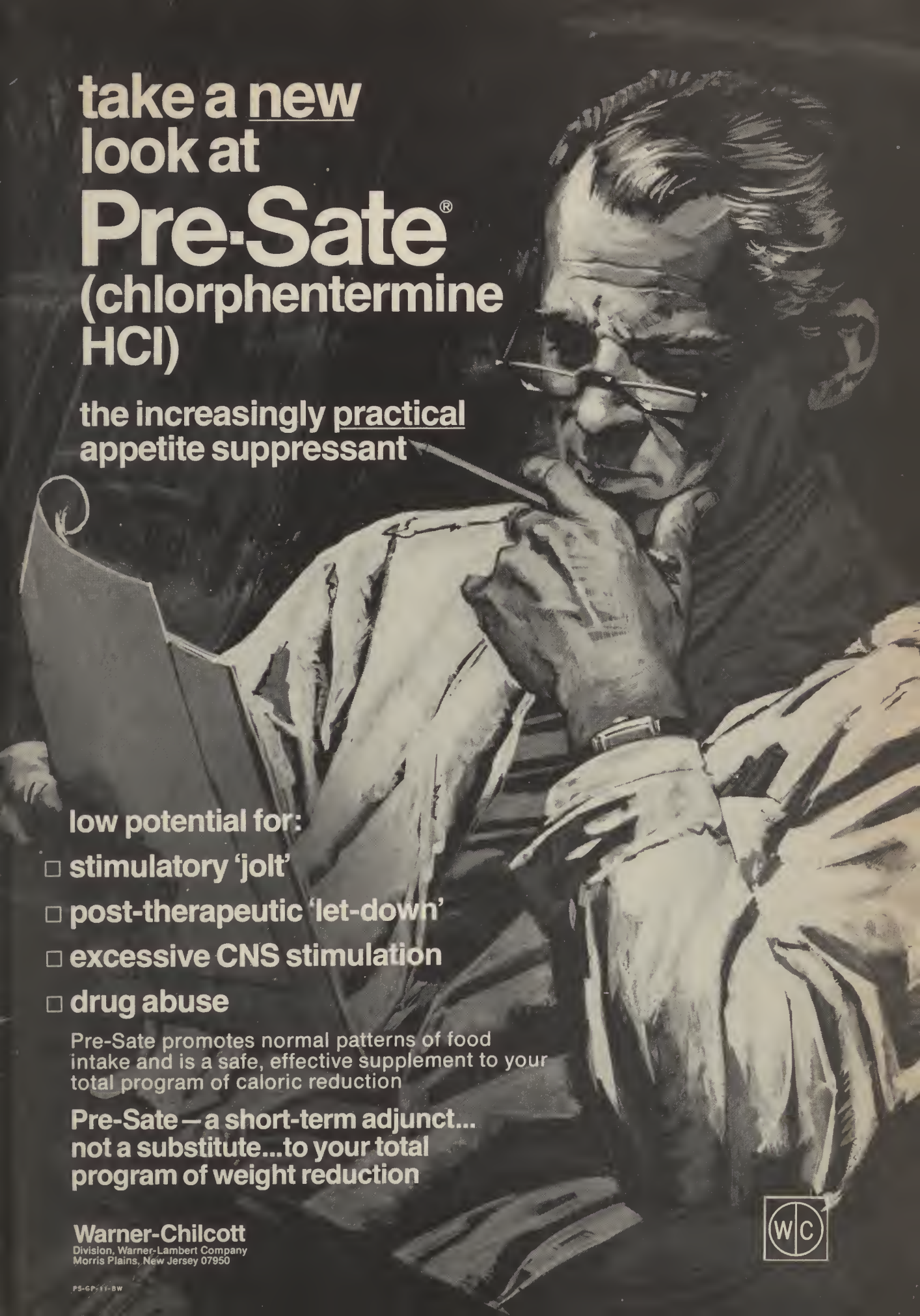
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infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

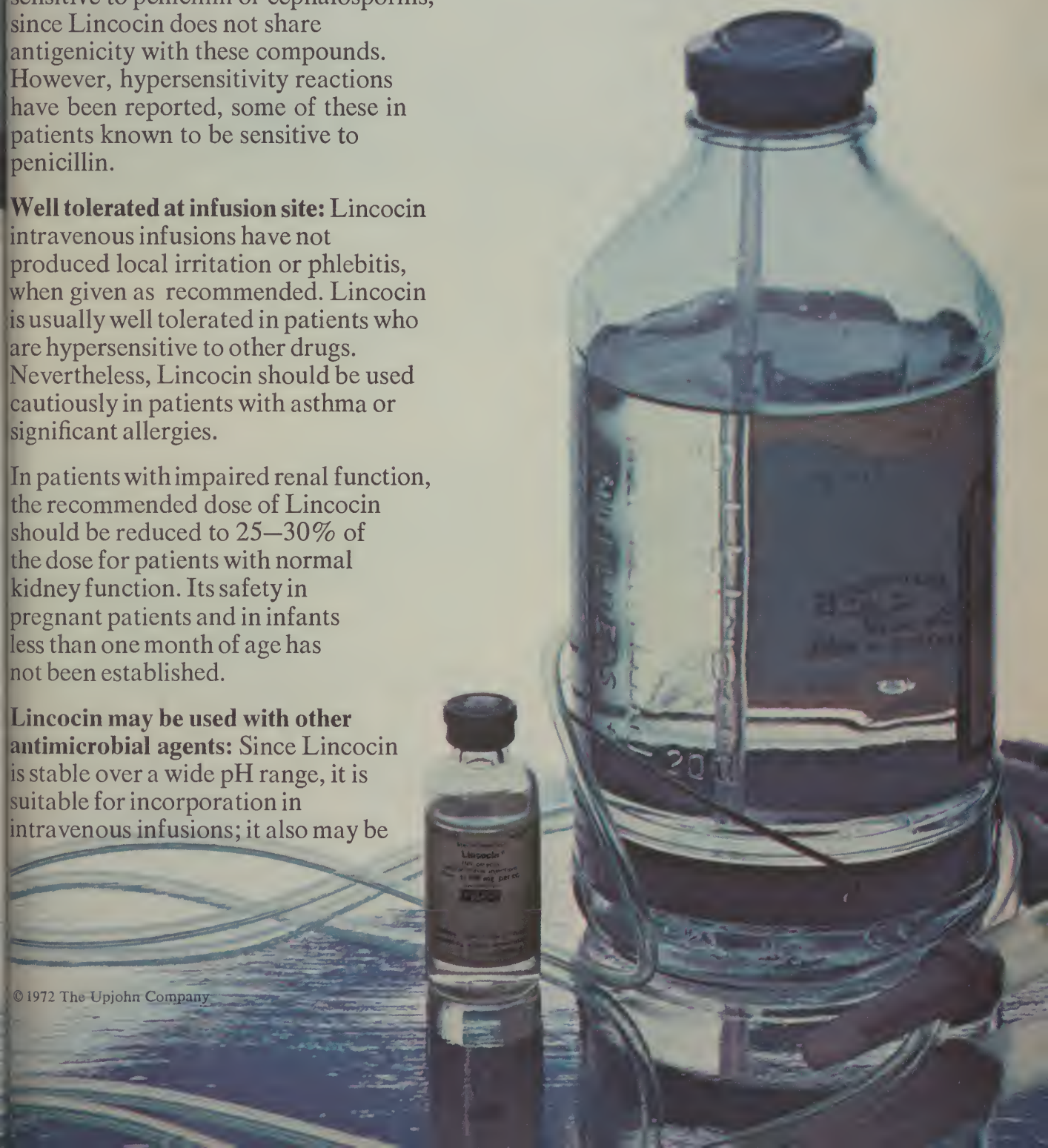
**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatme *Skin and mucous membranes*—Skin rash urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis ha been reported. *Liver*—Although no direct lationship to liver dysfunction is establish jaundice and abnormal liver function te (particularly serum transaminase) have be observed in a few instances. *Cardiovascu* —Instances of hypotension following pare teral administration have been reporte particularly after too rapid IV administ tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adm istered IV, dilute in 500 ml of fluid a administer no faster than 100 ml per ho *Special senses*—Tinnitus and vertigo ha been reported occasionally. *Local reactio* —Excellent local tolerance demonstrated intramuscularly administered Lincoc (lincomycin hydrochloride). Reports of pa following injection have been infreque Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distill water or normal saline has produced local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 m* Capsules—bottles of 24 and 100. *Ster Solution, 300 mg per ml*—2 and 10 ml vis and 2 ml syringe. *Syrup, 250 mg per 5* —60 ml and pint bottles.

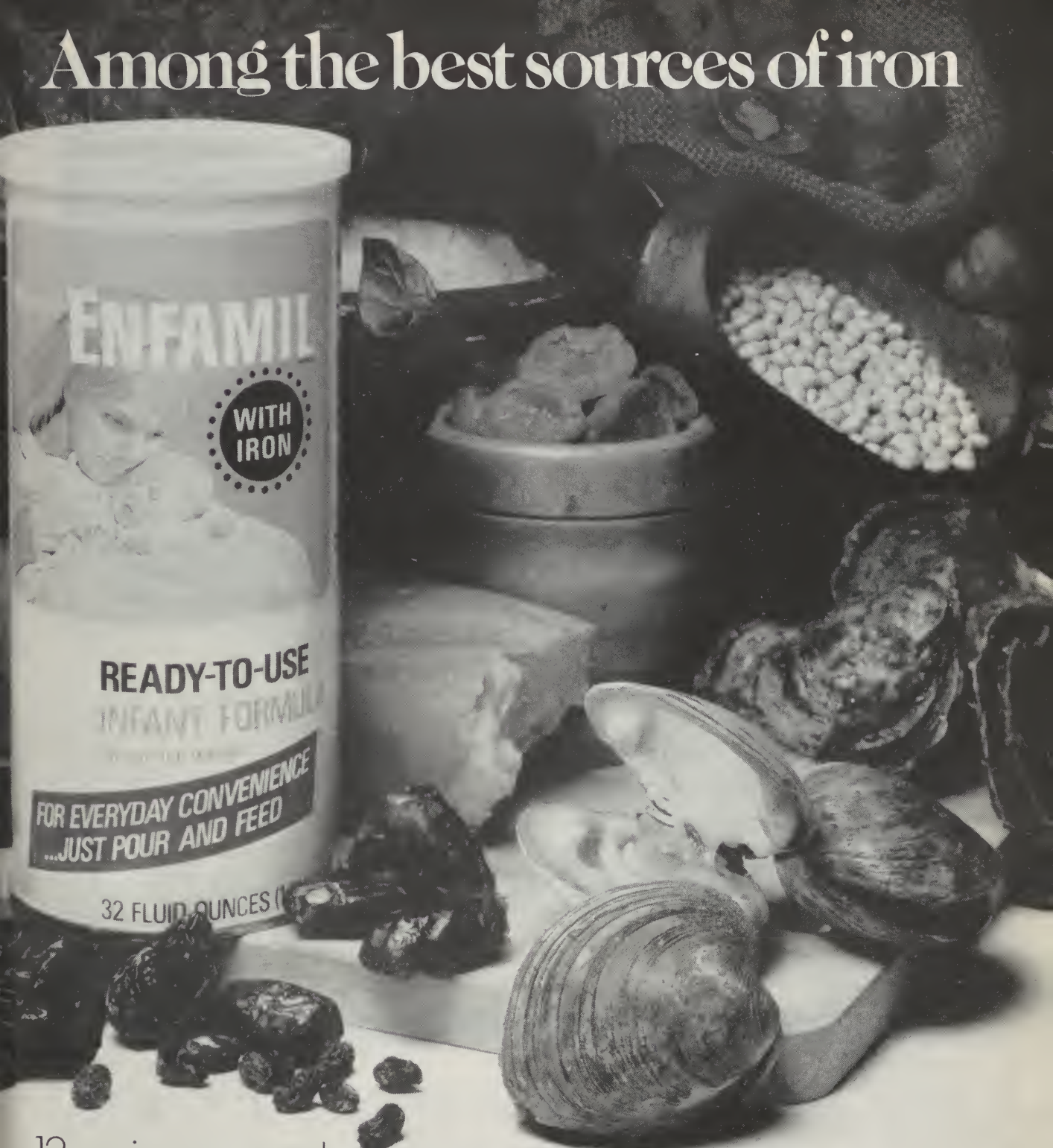
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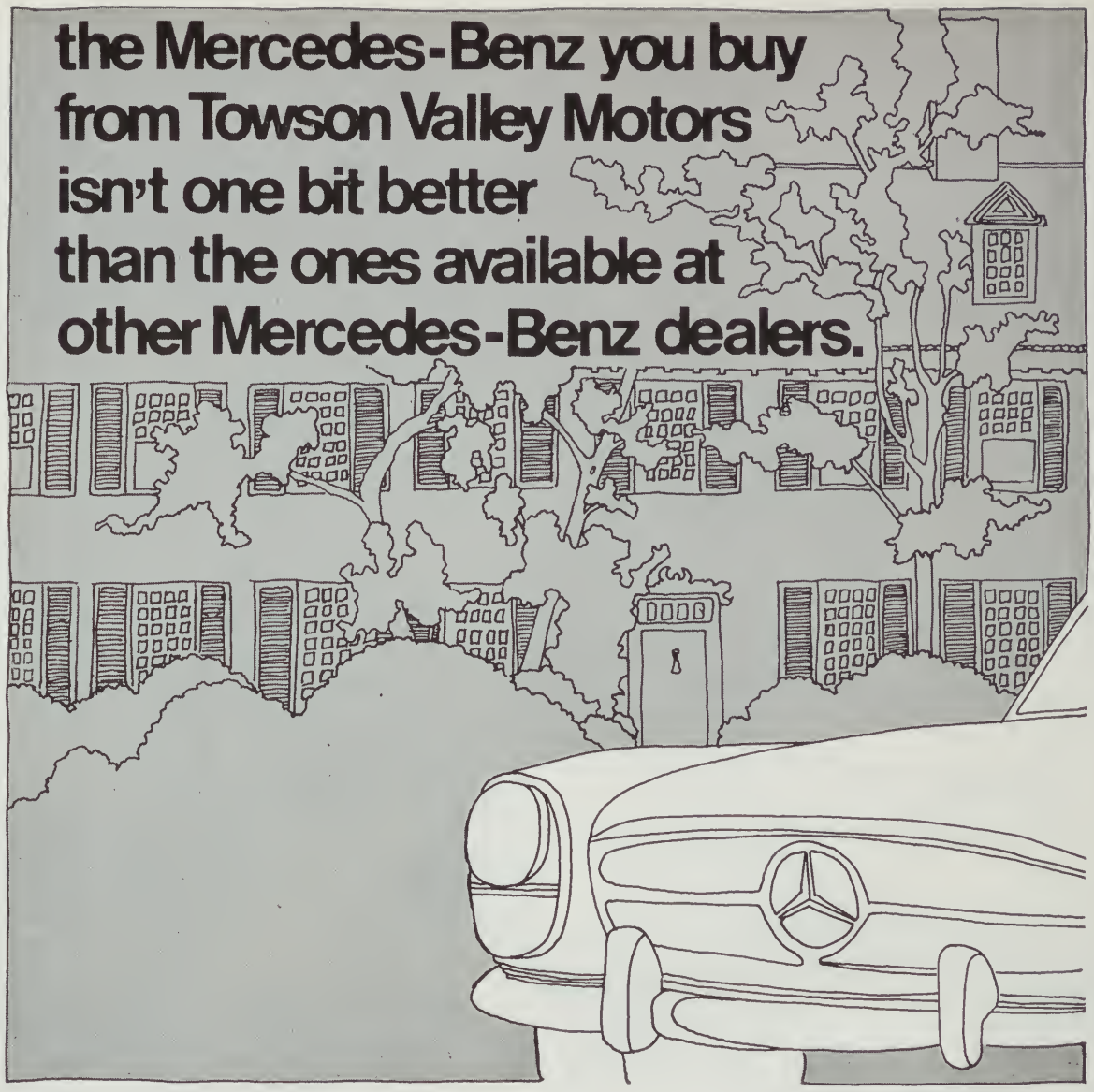
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# What Do We Know and What Can We Do About Our Environment?

A healthy environment is everybody's business and everybody's problem. Once upon a time our rivers and streams were crystal clear and pure; our beaches were unspoiled by man; and the air was magnificently refreshing to breathe. But, slowly, through the years, man has fouled his nest.

Our conversations and reading materials are filled with such phrases as dirty water, polluted air, people pollution, poor conservation, noise pollution, awful smog, and lousy litter.

How well-informed are you on environmental issues? Test your ecological prowess on the following National Environment Quiz and see where you stand.

1. The deadliest periods of air pollution have occurred during the summer months. (True - False)

2. The fish in Lake Erie disappeared because of lack of oxygen. (True - False)

3. Drinking water sources are often used as disposal sites for sewage. (True - False)

4. Most of the DDT in our bodies comes from the air we breathe. (True - False)

5. What is the source of most of the nation's air pollution? (Factories - Incinerators - or Automobiles)

6. Most communities dump their sewage into nearby waters without any treatment. (True - False)

7. Pesticides kill only those insects and animals that are harmful to us. (True - False)

8. Which container will create the least waste disposal problem? (Returnable Bottle — No-deposit Bottle — Aluminum Can)

9. As much solid waste is created by individuals as by manufacturing. (True - False)

10. Which cleanser will produce less water pollution? (Non-sudsing Detergent—or Soap Flakes)

**ANSWERS**

*(Score ten points for each correct answer.)*

1. False. A weather condition known as temperature inversion which usually occurs when temperatures are low, makes winter a prime time for deadly pollution periods. During colder months the less dense, upper air masses tend to be heated more quickly by the sun that the cold and heavily polluted air masses near the ground. When there is inadequate circulation of the upper air masses, the lower masses become trapped under a blanket of warm air. This blanket seals in pollutants which would ordinarily be dispersed into the upper air.

2. True. Algae, overnourished by wastes spilling into the lake, grew wildly, and then died. The decayed bacteria feeding on the algae consumed most of the oxygen in the lake. Treatment plants in the area remove only 50% of the pollutants from the sewage spilled into the waters.

3. True. Many communities in the nation dump sewage into rivers and lakes (sources of drinking water).

4. False. Most of the DDT comes from food, through sprayed vegetables and fruits or through the food chain.

5. Automobiles account for 60% of the nation's air pollution.

6. False. The communities dumping raw sewage into rivers number only about 10%. How-

ever, the majority of treatment plants are inadequate, filtering out only solid wastes (primary treatment) or solid and organic wastes (secondary treatment). Only ten small communities in the whole country have a third level of treatment which purifies chemical pollutants.

7. False. Not only do they kill innocent animals and birds, but pesticides are getting into the food chain, contaminating the food we eat.

8. Returnable bottle.

9. True. Into the family trash goes about three pounds of solid waste per person per day.

10. Soap flakes break down into harmless substances once down the drain; detergents do not.

**SCORING:**

100 — Ecologically aware!
80-90 — Moderate polluter
60-70 — Chronic litterbug
50 or less — Environmental hazard!

Waste is all around us. It is a major problem in every community, and its removal is a great expense. We are all consumers because of the great rate at which we produce and purchase. Much of what we produce and purchase comes in a package—a plastic wrap, a box, a can, a carton or other paper container—and this creates a problem! Also, things we use, like cars, wear out, and are piled up in great heaps, spoiling the landscape.

The Woman's Auxiliary to the AMA is encouraging its auxiliaries to consider environmental health projects. Doctors' wives can be very effective as pollution fighters. The Health Education Committee provides materials for programs of lectures, films and discussion groups, for the medical groups, and for the public. It is the responsibility of the medical family to make the public aware of the problems of pollution of air, water, and earth and how they affect their health and future. Stricter laws against open dumping and burning should be encouraged. Industry should change certain methods of production in order to cut down on pollution. Let the government officials, city, county, state and federal, know of your deep concern, and demand theirs!

Clean-up campaigns, involving the entire community, should be sponsored. Collections can be made of newspapers, bottles, cans, rubber from old tires, and other eyesores that can be recycled. Schools, churches, boy and girl scouts, campfire girls, civic clubs, and the PTA should be involved.

The educational program should start in the doctor's home. Children can be taught to help with the pollution solution. They should be urged to put trash in the proper places so as not to be litter bugs. Start a compost pile, thereby returning nutrients to the soil. Purchase cleaning products that are the least polluting, and articles that can be reused. Walk more and ride less, and insist on lead-free gasoline. Turn off lights when they aren't being used, and don't blow the horn unless there is a reason. Alert your local or state agency when you detect an odor, smoke, or smog. Only then can they seek the source.

Pollution control is costly, but the alternative is more expensive! Making ill people well will cost much more, both in money and human suffering. If every individual will do his part to clean up his environment and keep it that way by limiting his contribution to pollution the fight can be won.

Doctors and their wives, as medical society and auxiliary members and as citizens, can join forces, share their knowledge and "know-how" with others, and can lead the way to a healthier environment!

The AMA has excellent materials available to help with educational and action programs. Make use of them!


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## THOMAS WILLIS

Thomas Willis was one of the greatest innovators in seventeenth century British medicine. His was the first comprehensive theory of brain localization, along with the first description, in western medicine, of sugar in urine in diabetics, and the first clear concept of reflex action. Yet today, few people know of more than one particular connected with his name: the circle of Willis. Willis' greatness is largely overshadowed by other figures who built upon his work and studies. Robert Hooke, John Locke, and Richard Lower were among the students of Willis. Consequently, Willis has been all but forgotten to medical history.

The Medical and Chirurgical Faculty Library possesses a first edition of Willis' **Cerebri Anatome** from 1664. This beautiful volume, illustrated by Sir Christopher Wren, was the most complete and accurate account of the nervous system of its time. The library also possesses a 1679 edition of Willis' **Pharmaceutice Rationalis.** In addition, the library has recently purchased Dr. Hansruedi Isler's **Thomas Willis, 1621-1675: Doctor and Scientist.** This recent work is the first complete account of Willis' life and work, and of his influence in the development of medical science.

These items are available for examination and study at the library.

JOSEPH E. JENSEN
Assistant Librarian

## NEW ACCESSIONS – BOOKS (Arranged by Subjects)

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Barnard, Christiaan Neethling. **Christiaan Barnard: one life.** By Dr. Christiaan Barnard and Curtis Bill Pepper. New York, Bantam Books, 1971. History WZ 100 B 3 1970.

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The Institute for Cancer Research. **Fifteenth Scientific Report.** Philadelphia, 1970. QZ 206 16.

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### March 3, 1972 12:30 PM

#### THE THERAPY OF COAGULATION DISORDERS

**Earl W. Campbell, MD**
Consultant in Hematology
National Cancer Institute
National Institute of Health

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Replays: Monday, March 6, 1972 12:30 PM
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### March 10, 1972 12:30 PM

#### CLINICAL PROBLEMS IN CONNECTIVE TISSUE DISEASE

**Mary Betty Stevens, MD**
Associate Professor of Medicine
Physician-In-Charge, Arthritis Clinic
Associate Physician-In-Charge, Connective Tissue Clinic
Associate Physician-In-Charge, Polyarthritis Clinic
Johns Hopkins University School of Medicine
Chief of Connective Tissue Division
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

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#### FIVE-YEAR EXPERIENCE OF CORONARY CARE UNIT—BALTIMORE CITY HOSPITALS

**Gustav C. Voigt, MD**
Chief, Cardiovascular Division
Baltimore City Hospitals
Assistant Professor of Medicine
Johns Hopkins University School of Medicine

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#### HOST DEFENSE MECHANISMS

**Dexter Seto, MD**
Assistant Professor of Pediatrics
Assistant Professor of Microbiology
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

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**Vernon M. Smith, MD, FACP**
Professor of Clinical Medicine
University of Maryland School of Medicine
Chief of Gastroenterology
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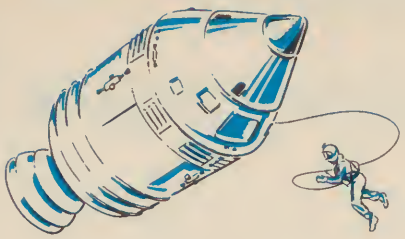
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# Call it what you will, it may be premalignant..

## Before

**3/29/67** Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

**6/12/67** Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



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# and Efudex® (fluorouracil) 5% cream can resolve it.

## Call it actinic, solar or senile keratoses, many regard it as "precancerous."[1,2]

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,[3,4] offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these mutliple lesions.

## Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.[5] Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.[6]

## Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.[5] The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.[6]

## How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

## Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

**References:** 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).




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# MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

## MAY 3, 4, 5, 1972

Baltimore Civic Center

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(as of January 15, 1972)

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# SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 3, 4, 5, 1972
Baltimore Civic Center

**Ample space is available, however, it is suggested that applications be submitted as soon as possible.**

## RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

## APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

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5. Has exhibit been shown at other medical meetings? _____

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6. Name and title of exhibitor: _____

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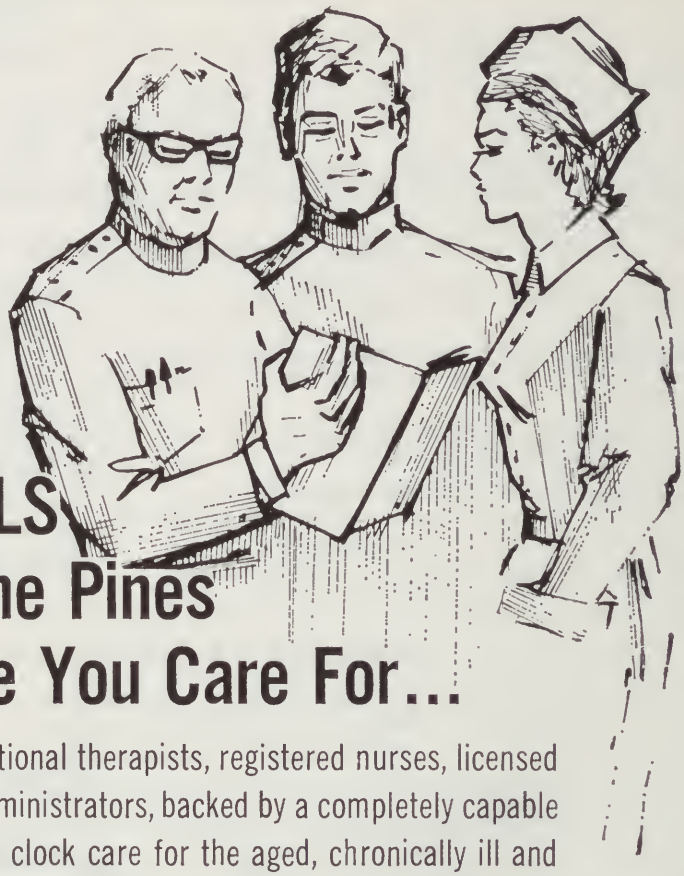
7. Name of institution cooperating in the exhibit: _____

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8. Address of exhibitor: _____

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Bristol Laboratories ..... 79
Burroughs-Welcome Co. ..... 27, 101
Campbell Soup Co. ..... 47
Capital Savings & Loan Association ..... 108
Oscar Caplan & Son ..... 12
Chesapeake Cadillac Co. ..... Cover 3
Community Health Facilities ..... 43
Connecticut Mutual Life Insurance Co. ..... 80
Franklin Uniform Co. ..... 35
Geigy Pharmaceuticals ..... 1, 111-113
Herget & Co. ..... 108
House in the Pines Nursing Homes ..... 106
Lederle Laboratories ..... 23-26
Eli Lilly & Co., Inc. ..... 7
Lucas Brothers ..... 18
Mead Johnson Labs. ..... 91
Merrell-National Labs. ..... 77-78
Monarch Lincoln Mercury ..... 107
Morstein's Jewelers ..... 12
Nationwide Pension Planning ..... 81
Orient Adventure ..... 11
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T. Rowe Price ..... 104
Professional Management Co. ..... 15
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Geo. Radebaugh & Sons ..... 15
Reed & Carnrick ..... 114
Read's Drug Stores ..... 43
A. H. Robins Co. ..... 51-53
Roche Laboratories ..... Cover 4, 2-3, 102-103
Roerig & Co. ..... 30
Russell, Marsh & Kennedy, Inc. ..... 6
Manuel Schwartz Hearing Rehabilitation 108
G. D. Searle Co. ..... 48-50
Security Business Services, Inc. ..... 83
Smith Kline & French Laboratories ..... 37-38
Special Diet Shop ..... 108
Sterling Lighting Co. ..... 108
Stuart Pharmaceuticals ..... 28-29
Mano Swartz—Furs ..... 12
Tio Pepe Restaurant ..... 94
Towson Valley Motors ..... 92
Upjohn Co. ..... 44-45, 88-90
USV Pharmaceuticals ..... 31
Van Dyke & Bacon ..... 98
Warner-Chilcott Labs. ..... 86-87
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*Warnings:* Use during pregnancy is to be avoided.
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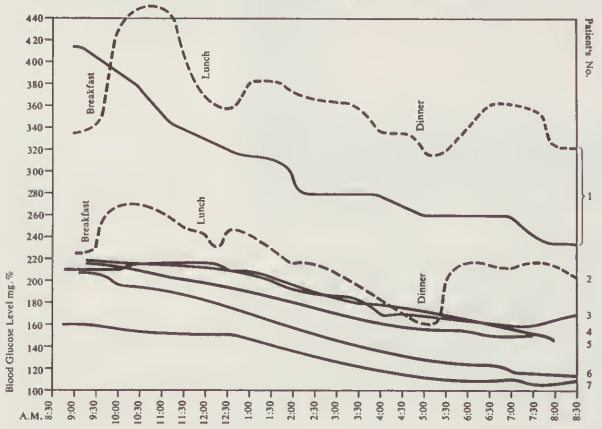
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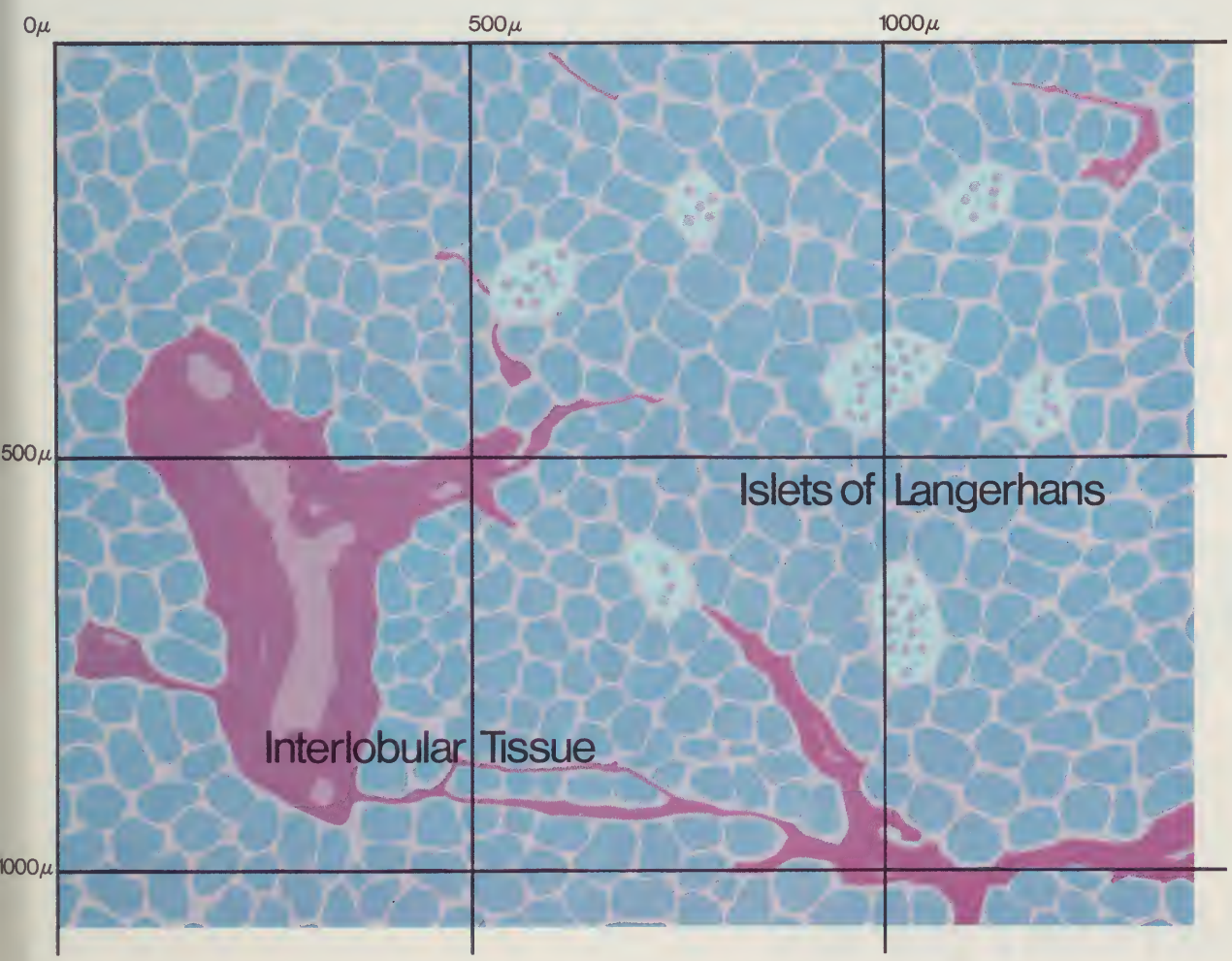

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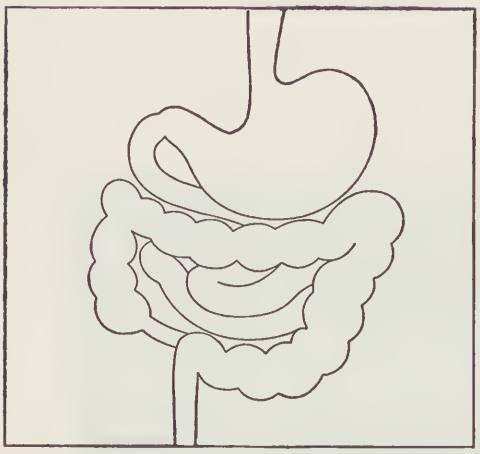
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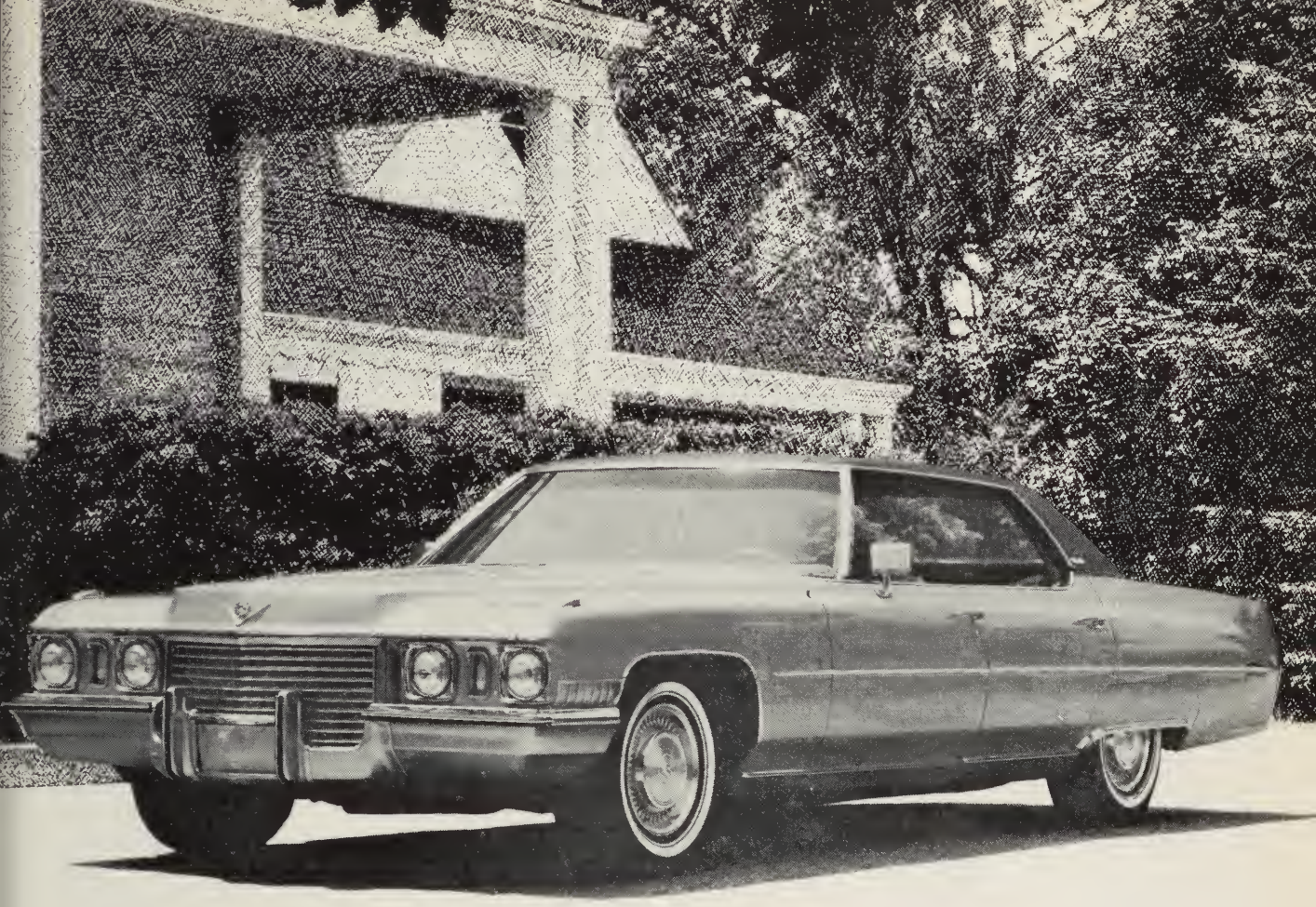
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# can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.
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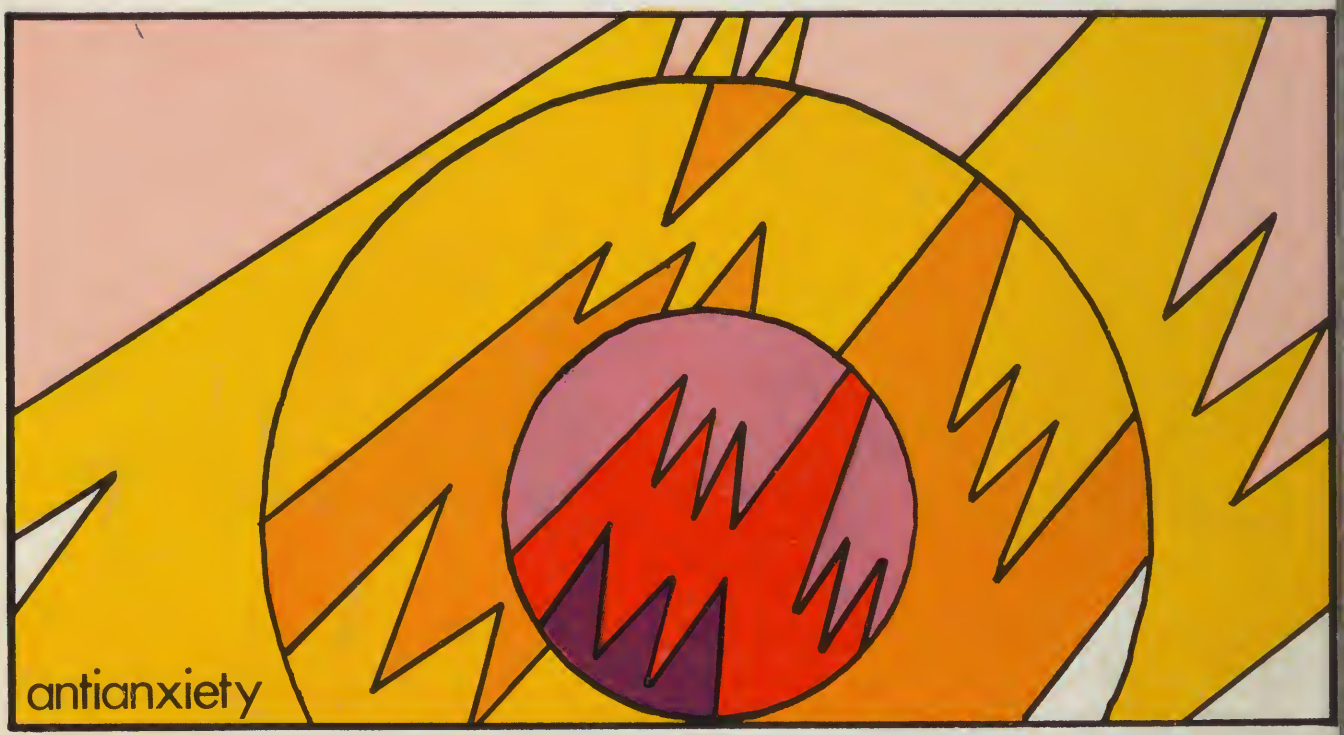
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# anxiety: a time bomb

Unless "defused," anxiety may build up to an intensity that can overwhelm the patient's inner defenses. Also, in one weakened by chronic illness or surgery, excessive anxiety may provoke or aggravate symptoms and interfere with recovery.

The antianxiety action of Librium (chlordiazepoxide HCl)—used adjunctively or alone—has demonstrated clinical usefulness in many fields of medical practice where anxiety complicates the patient's condition.




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## (chlordiazepoxide HCl) 5-mg, 10-mg, 25-mg capsules up to 100 mg daily for severe anxiety

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libida—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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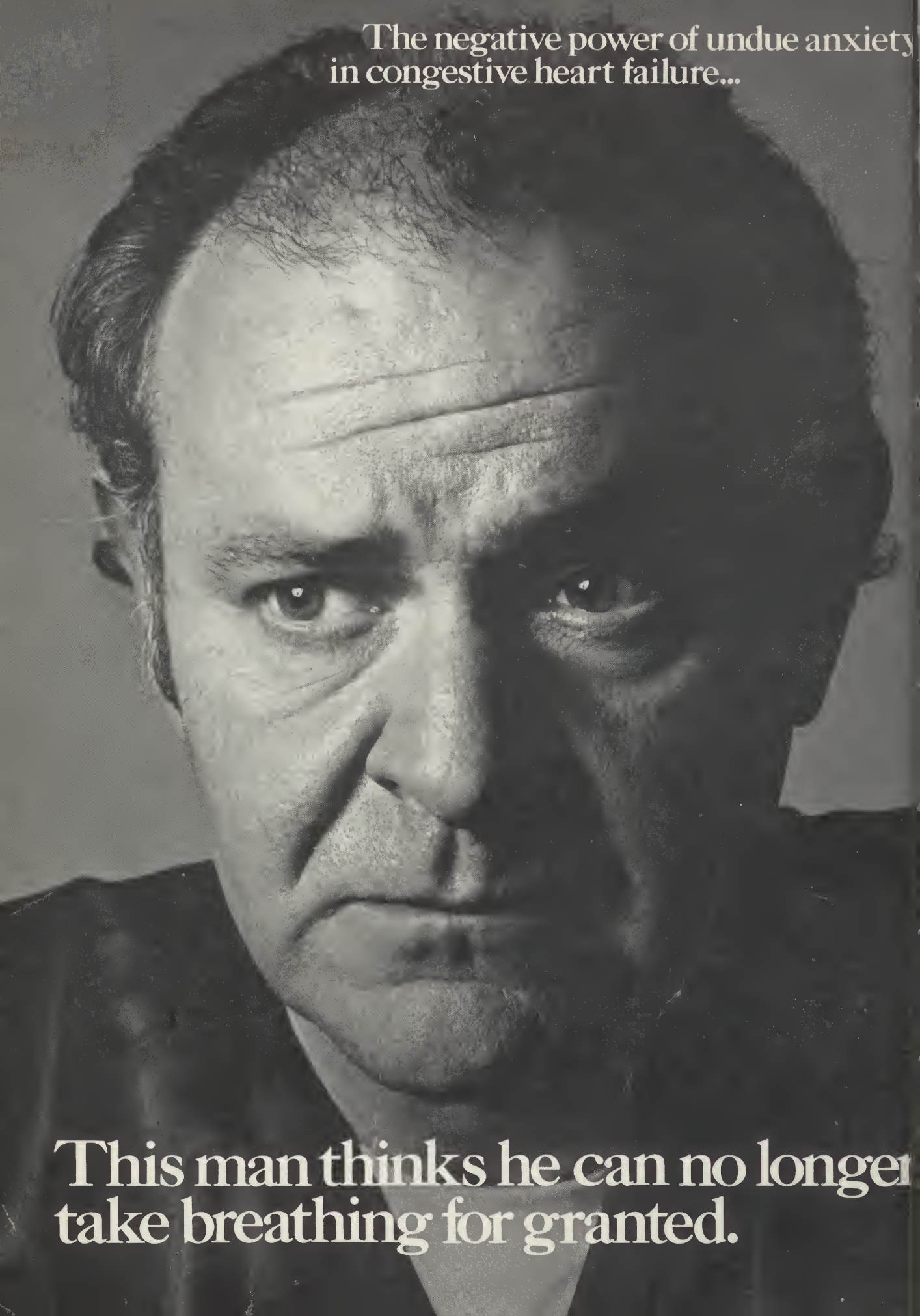
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## STATE MEDICAL JOURNAL

MARCH 1972

READING ROOM



SACRED HEART HOSPITAL
CUMBERLAND


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

**Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.**

*Aid in rehabilitation*

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

*Concomitant use with primary agents*

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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up to 100 mg daily

## for severe anxiety accompanying congestive heart failure

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# maryland state MEDICAL JOURNAL

VOLUME 21 MARCH 1972 NUMBER 3


## ARTICLES:


**The Rising Cost of Health Care and Underutilization of Visiting Nurse Services in Baltimore**—T. D. Baker, MD.; J. D. Galkin, PhD; K. N. Williams, MA ..... 48

**Opportunities and Procedures for the Early Diagnosis of Carcinoma of the Cervix**—H. W. Jones, Jr., MD; H. J. Davis, MD; J. K. Frost, MD ..... 54

This panel-symposium, moderated by H. W. Jones, Jr., MD, was presented at the 171st Annual Meeting of the Medical and Chirurgical Faculty as the Hundley Memorial Lecture in Gynecology.

**Blue Shield and Health Care**—Ned F. Parish, President, National Association of Blue Shield Plans ..... 59


## DEPARTMENTS:


**Your Medical Faculty at Work**—John Sargeant ..... 7

**Heart Page—Trifascicular Concept of Ventricular Activation,** J. O'Neal Humphries, MD ..... 25

**Maryland State Department of Health and Mental Hygiene—A Study of Women Who Discontinue Family Planning Clinic Attendance**—D. S. Bachman, MD; G. R. Snyder, MD; J. K. Seegar, Jr., MD ..... 28

**Peer Review** ..... 36

**Woman's Auxiliary—Doctors' Day** ..... 37

**Rehabilitation Medicine—The Effect of Stroke on Well-Established Rheumatoid Arthritis**—E. E. Velayos, MD; B. S. Cohen, MD ..... 38

**Current Status of the Treatment of Alcoholism**—M. N. Weisman, MD ..... 73

**Library—Drug Alert, Bibliographies, Meetings, New Accessions** ..... 81

**Baltimore City Health Department—Health Highlights for 1971** ..... 84



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ON THE COVER — This month Med-Chi salutes Sacred Heart Hospital of Cumberland which majestically overlooks the city, nestled in the valleys of the surrounding Alleghany Mountains.

## MISCELLANY:


Doctors Take Note 4

Hospital Salute 5

Doctors in the News 6

Director's Newsletter 9

Medical News Briefs 12

Open Forum 18

Book Reviews 35, 101

Letters to the Editor 58

Semiannual Meeting News 72

Scientific Exhibits 92

Component Societies 94

Emergency Department Symposium News 95

MEDIC 96

Annual Meeting Hotel Reservation Forms 97, 113

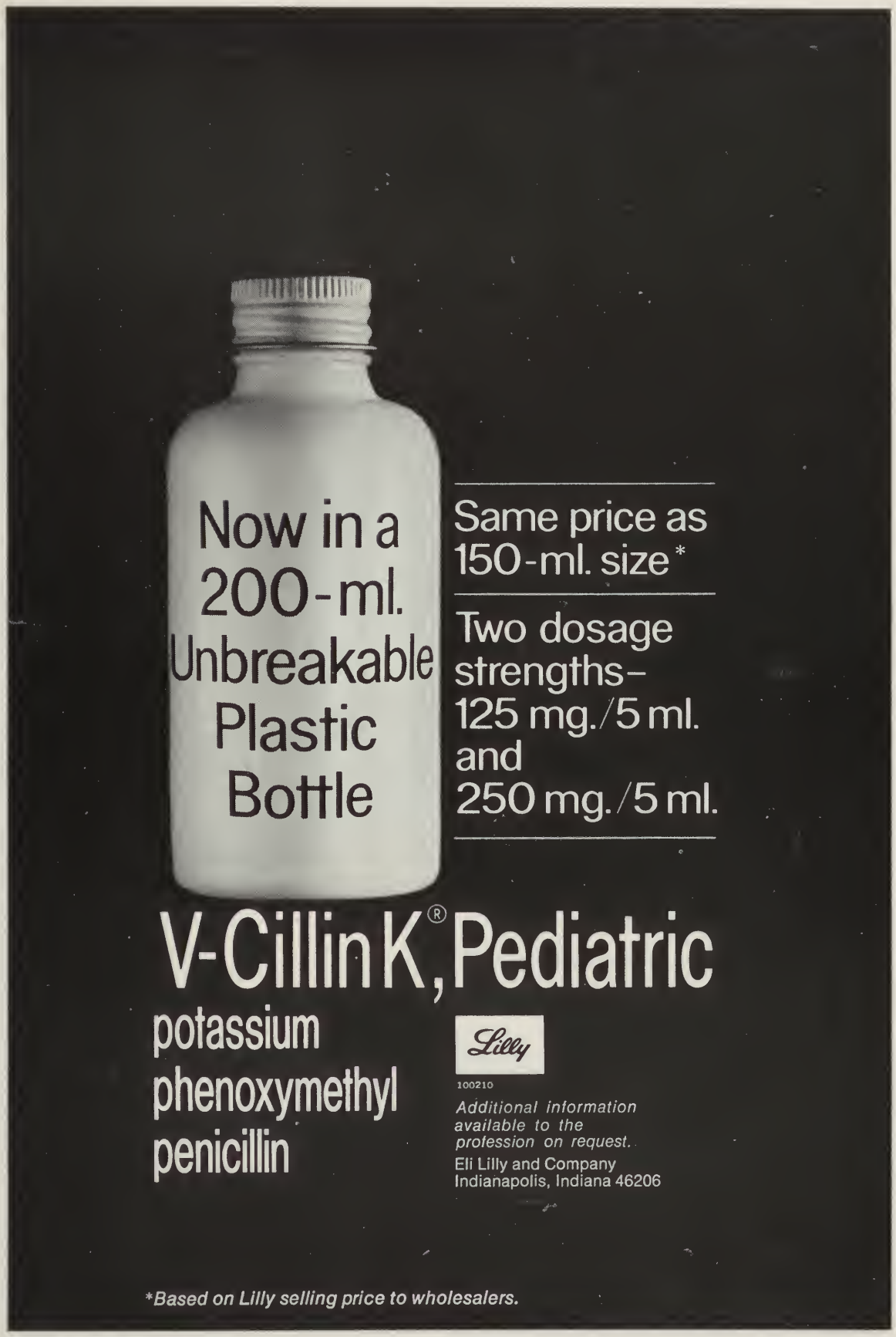
Annual Meeting Program Preview 102, 114

Annual Meeting Speakers 106

Ethics Corner 108

Classified Advertising 115

Advertising Index 116


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# Doctors take note...

## MARYLAND AREA MEETINGS

Mar 27-30 — **Southeastern Surgical Congress.** 40th Anl Assembly. Shoreham Hotel, Washington. Contact: Southeastern Surg Congress, 340 Boulevard NE, Atlanta Ga 30312.

Apr 15 — **Man & His Moods.** 4th Anl Taylor Manor Hosp Psychiatric Symposium. Contact: Symposium Secretary, Taylor Manor Hosp, Ellicott City Md 21043.

May 18-21 — **Maryland Academy of Family Physicians.** 24th Anl Mtg. Deep Creek Lake Md. Contact: Daniel Welliver MD, 19 Ridge Rd, Westminster Md 21157 or Mrs Dorothy E Holman, 10 Gerard Ave, Timonium Md 21093.

thru May 20 — **Current Psychiatric Practice & Patient Management.** Continuous medical education program to maintain & further develop psychiatry skills. Sponsor: Spring Grove State Hosp. Contact: Ramon A Boza MD, Director Psychiatric Educ & Trng, Spring Grove State Hosp, Baltimore Md 21228, tel 747-4400.

## AMERICAN COLLEGE OF PHYSICIANS

(All contacts ACP, 4200 Pine St, Phila Pa 19104.)

Mar 20-24 — **Specifically Treatable Diseases.** Philadelphia. Sponsors: Penna Hosp & Univ of Penna Med School. 34½ hrs crt.

Mar 27-29 — **The New Face of Pulmonary Disease.** Sponsors: Univ of Calif at Los Angeles & Center for Hlth Sciences.

Apr 5-7 — **Cardiology for the Internist.** Baylor College of Med, Texas Med Cen, Houston. 21 hrs cr.

Apr 17-21 — **American College of Physicians.** 51st Anl Session, Atlantic City.

## AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS

Mar 20-31 — **Course in Ob & Gyn** including clinical review of ob & gyn disorders & their med & surg mgt. Contact: Assoc Dean, Dept of Continuing Educ, Harvard Med School, 25 Shattuck St, Boston Mass 02115.

Mar 29 – Apr 1 — **Anaesthesia Analgesia & Resuscitation in Obstetrics.** Paris. Sponsor: Natl Congress of Anaesthesiology & Resuscitation. Contact: OITT Congres, 62 blvd du Montparnasse, Paris XV France.

Apr 19 — **Prenatal Diagnosis of Hereditary Disorders.** Chicago. Contact: Frontiers of Med, Univ of Chicago, 950 E 59th St, Chicago Ill 60637.

## MISCELLANEOUS MEETINGS

Apr 6-8 — **Health Services in the 70s.** 6th Natl Congress on Socio-Economics of Hlth Care, Fort Lauderdale Fla. Sponsor: AMA. Contact: Div of Med Practice, AMA, 535 N Dearborn, Chicago Ill 60610.

Apr 10-11 — **Cancer Seminar.** Flamingo Hotel, Las Vegas, Sponsor: American Cancer Society. Contact: Cancer Seminar, 301 S Highland Dr, Las Vegas Nev 89106.

Apr 17-20 — **American Industrial Health Conference.** Philadelphia. Sponsors: Ind Med Assoc & Amer Assoc of Ind Nurses. Contact: American Industrial Hlth Conf, 150 N Wacker Dr, Chicago Ill 60606.

Apr 24-27 — **American Academy of Pediatrics.** Anl Spring Session. San Diego. Contact: AAP, Dept of Public Info, 1801 Hinman Ave, Evanston Ill 60204.

Apr 27-29 — **Northeast Region of American Assoc of Med Clinics.** Anl Session. New Britain Conn. Sponsors: AAMC & Grove Hill Clinic. Contact: John C White MD, Grove Hill Clinic, New Britain Conn.

Apr 28 – May 1 — **Student American Med Assoc.** 22nd Anl Mtg. Los Angeles. Sponsor: Student AMA. Contact: Student AMA, 1400 Hicks Rd, Rolling Meadows Ill 60008.

| | | |
|---|---|---|
| May | 1-3 | **American College of Sports Med.** 19th Anl Mtg. Philadelphia. Contact: D E Hermann, ACSM, 1440 Monroe St, Madison Wisc 53706. |
| May | 6-9 | **Medical Society of New Jersey.** 206th Anl Mtg. Atlantic City. Med-Chi mbrs invited to submit scientific exhibits. Contact: MSNJ, PO Box 904, Trenton N J 08605. |
| May | 8-10 | **Health Sciences Communications Assoc.** 14th Anl Mtg. Toronto. Contact: Bruce P. Squires. Dept of Physiology, Univ of Western Ontario, London 72 Canada. |
| May | 10-12 | **American Public Health Assoc.** 40th Anl Mtg. Hollywood Fla. Southern Branch. Contact: APHA, 1025 S 18th St, Birmingham Ala 35205. |
| May | 10-13 | **Trauma Course.** Chicago. Sponsor: Chicago Committee on Trauma of American College of Surgeons. Contact: ACS, 55 E Erie St, Chicago Ill 60611. |

## Med-Chi Salutes

# SACRED HEART HOSPITAL



Allegany Hospital was founded in 1905 by a group of physicians and businessmen. The Sisters of Charity took over the operation of the hospital in 1911. It had 25 beds at that time and was located on Decatur Street.

Several expansion programs were undertaken during the time the hospital was located there. The largest was construction of a five-story annex in 1937.

In 1951 the name of Allegany Hospital was changed to Sacred Heart Hospital.

In the early 1960s, plans were made to build the new Sacred Heart Hospital. Construction began on the new facility in late 1964 at its present site on top of Haystack Mountain. Patients were moved from the building on Decatur Street to the new building on Seton Drive on March 28, 1967.

Sacred Heart Hospital, with its 247 beds, is a community hospital, operated by the Daughters of Charity of St. Vincent de Paul, providing a wide range of health services to the residents of Allegany County and vicinity.

It is fully accredited by The Joint Commission on Accreditation of Hospitals. Sister Mary Louise is Administrator.


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# Doctors in the News



Dr. McIntyre

**David B. McIntyre,** MD, has been named president of the medical staff of Baltimore's St. Agnes Hospital. A graduate of Potomac State (WVa) College, Dr. McIntyre received his BS and MD degrees from the University of Maryland. He served an internship and completed his residency in OB-GYN at St. Agnes.

Other 1972 medical staff officers include: **Stephen K. Padussis,** MD, immediate past president; **Edwin H. T. Besson,** MD, president-elect; and **John P. White III,** MD, secretary-treasurer.

•

According to JOURNAL representative **Ernest A. Dettbarn,** MD, the Frederick County Medical Society officers for 1972 include the following physicians: president, **Robert J. Thomas;** president-elect, **Robert R. Roberts;** secretary, **Timothy Hickey;** and treasurer, **J. Fred Baker.**

**Charles Conley** has been elected to a one-year term on the executive committee. Delegates are **George Smith, Jr.,** and **Charles Wright. J. Fred Baker** and **Richard Fruth** will serve as alternate delegates.

**Frank J. Otenasek,** MD, has been elected president of the medical staff of Bon Secours Hospital in Baltimore. Dr. Otenasek is a graduate of Loyola College and The Johns Hopkins Medical School.

He is associate professor of neurological surgery at Hopkins and an instructor of neurological surgery at the University of Maryland.

•

**A. E. Cocco,** MD, has announced the relocation of his office for the practice of gastroenterology to 20 East Eager St., Baltimore, Md. 21202.

•

**Jules Masserman,** MD, professor of neurology and psychiatry and cochairman of psychiatry at the Northwestern University School of Medicine, will receive the 1972 Taylor Manor Hospital Psychiatric Award.

Dr. Masserman will receive the plaque at the Award Luncheon during the Fourth Annual Taylor Manor Hospital Psychiatric Symposium being held in Ellicott City, Md., April 15, the theme of which is "Man and His Moods."

•

The Harford County Medical Society is being served by these physicians as 1972 officers: **Karl K. Namvary,** president; **Henry H. Kwah,** vice-president; **Olga M. Gatewood,** secretary; and **Edward Simon,** treasurer. Delegates are **Philip W. Heuman** and **Emory J. Linder.** Alternate delegates are **Dudley Phillips** and **Allen Silver.**

•

**George E. Urban, Jr.,** MD, of Silver Spring and Marlow Heights, has been elected a Fellow of the American College of Surgeons.

**J. Sanford Young,** MD, Oxon Hill, has been elected to his second term as president of the medical staff of the Morris Cafritz Memorial Hospital in Washington.

•

**Horace W. Bernton,** MD, Bethesda internist, was recently installed as president of the Montgomery County Medical Society at a dinner-dance at the Woodmont Country Club. He succeeds **Robert G. Angle,** MD, also of Bethesda. Dr. Angle also received the Henry P. Laughlin Award as the physician who contributed most to the Society during the past year.

•

Three Baltimore MDs have been granted American Cancer Society support for special training in cancer work. The three ACS Clinical Fellows, all from Johns Hopkins, are **Benjamin F. Hughes, Michael E. Jabaley,** and **James R. Reynolds.**

Dr. Hughes is specializing in urology, Dr. Jabaley in plastic surgery, and Dr. Reynolds in surgery.

•

**Darrell C. Crain,** MD, Montgomery County, has been elected president of the Medical Society of the District of Columbia. He also serves as clinical professor of medicine at Georgetown University.

•

The Maryland Society for the Rheumatic Diseases has elected these MDs as 1972 officers: **Werner Barth,** president; **Mary Betty Stevens,** president-elect; **James M. Sowa,** secretary; and **K. A. Peter vanBerkum** and **Ernest C. Brown,** committeemen.

# your medical faculty at work

**by John Sargeant, Executive Director**

**The Council met on Thursday, January 20, 1972 and took the following actions:**

1. Adopted the proposed 1972 budget as recommended by the Executive Committee and in accordance with Article III, Section 11 of the Bylaws.
2. Reaffirmed the action of the Mediation Committee in respect to Guidelines for Definition of Cerebral Death and the waiting period related thereto.
3. Approved and endorsed a proposed project of the Greater Baltimore Alcohol Safety Project that requires taking of blood alcohols on all injured drivers who are treated in specified hospital emergency rooms. In its initial stage, the project will encompass only two hospitals, and is related only to those drivers injured in the areas of the Baltimore Beltway.
4. Considered discussing further a proposed Committee on Health Care of the Poor at a later date when more information is available as to what other groups have this subject under study.
5. Adopted a recommendation of the Library and History Committee that would provide up to 50 Xerox copies of articles free of charge to all members each month, on request and non-cumulative.
6. Reaffirmed previous policy with respect to expenditures from the Educational Fund, as adopted by the Council in 1965.
7. Adopted various recommendations to be made to the Blue Shield board for possible appointment to the Board as well as Committees of the Board.
8. Voted unanimously to oppose inclusion of psychologist services by legislative fiat under Blue Shield programs.
9. Agreed to write *The Sunpapers* regarding a medically unsound statement that appeared in the January 1, 1972 issue regarding a "cure for hangovers."
10. Adopted a position of opposition to legislation that would permit pharmacists to substitute brand names or generic drugs for the drug prescribed by physicians, dentists, etc.
11. Adopted a resolution honoring Francis X. Ballasone, former chief of the Division of Drug Control, State Department of Health and Mental Hygiene, who died on January 2, 1972.
12. Heard of receipt of an additional sum of money towards the Laughlin Award Fund.
13. Heard that the Grant E. Ward Memorial Fund now totals $4,685.
14. Approved a recommendation of the Policy and Planning Committee that 50-year certificates be given to 50-year members in addition to 50-year pins.
15. Formally acknowledged receipt of the following items from the Misses Annan of Taneytown, Md.:

    Picture of William Cullen, MD
    Miniature of Upton Scott, MD, founder of the Faculty
    Handwritten letter of 1772 by William Cullen, MD
16. Approved publication of the Findings of Fact in cases handled by the Commission on Medical Discipline. The publication will be in the *Maryland State Medical Journal* and will be on a retroactive basis.
17. Referred to the Committee on Medicine and Religion the question of Faculty participation in a proposed seminar on Ethics and Legal Jurisprudence on Human Life. This was proposed by the Secretary of the Department of Health and Mental Hygiene and would include religious and legal leaders in the program format.
18. Approved the mailing of a covering letter by the President dealing with an RMP survey on continuing education wishes of physicians in the outlying areas of the state.
19. Approved expenditure of funds for a special mailing dealing with a solicitation of any complaints members may have in connection with Blue Shield.
20. Adopted a new personnel policy with respect to retirement of employees at age 70.
21. Approved the Faculty's annual contribution to the Maryland League for Nursing.

At this meeting, a representative of the University of Maryland Student AMA Chapter was present as an observer.



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# executive director's newsletter

March 1972

NATIONAL HEALTH EXPENDITURES

National Health Expenditures Rose $7.2 Billion in fiscal year 1971, but the share of health care dollar received by physicians continued its seven-year decline. Total expenditures climbed slightly above $75 billion, with physicians' services accounting for $14.2 billion, up from $12.9 billion in 1970, the Social Security Administration reported. Of the total received by physicians 75.1% came from private funds and 24.9% from federal, state, and local funds. The report showed that physicians received 19% of the total funds spent for health care. That was down from 19.1% in 1970 and 21.5% in 1965. Physicians received 12.4% of the $28.4 billion spent on health care through public funds. Private expenditures for health care increased from $42.7 billion to $46.5 billion, while public expenditures increased from $25 billion to $28.4 billion. Hospital care expenditures rose from $26 billion to $29.6 billion. Detailed data and analysis of fiscal year 1971 health spending appeared in the January issue of the Social Security Bulletin.

PARIS TRIP

There are only a few places left on the Paris trip, scheduled for May 14 through 21. Reservations may be made through Travel Guide Agency, Mrs. Beverly Wolins, at SA 7-0680 or HU 4-2797. Cost of $399, plus departure taxes, includes transportation, breakfasts, hotel, and all sight-seeing tours.

DIRECTORY LISTINGS

Considerable confusion is being added to the field of directories by fly-by-nights who are sending out bills to indicate that directory listings are now due and payable by Maryland physicians.

In general, such listings are unethical, particularly if a charge is made for them. In addition, directories published must list all physicians without regard to payment or they are considered unethical.

Lastly, the Faculty's own 1972 directory is scheduled for publication within the next 2 to 3 weeks, a copy of which will be mailed at no charge to all members.

GRANT E. WARD MEMORIAL LECTURESHIP

A group of outstanding Maryland physicians has organized the Grant E. Ward Lectureship and has been soliciting funds from patients, friends, and fellow physicians. Those interested in making contributions should send them to the Faculty office and make checks payable to the Grant E. Ward Lectureship Fund.

ORIENT ADVENTURE

Reservations can still be made for the Faculty's Orient Adventure, scheduled for 14 days from July 23 through August 6. Scientific programs have been arranged for the 7 days in Tokyo and 7 days in Hong Kong.

Full details may be obtained through the Faculty office; cost of the trip is $898, plus taxes.

POSTING OF FEES

Under Price Control regulations of the federal government, physicians are required to post in their offices a sign indicating that a list of fees charged for procedures performed by the physician is available on request.

All other health providers are also required to abide by the same ruling such as Dentists, Physical Therapists, Osteopathic Physicians, etc.

AMA MEETING

The AMA Annual session is being held in San Francisco from June 18 to June 22. Hotel reservations are always at a premium during this time. Those persons who are planning to attend should send in reservations as promptly as possible. Complete details may be found in a current issue of the JAMA.

DATES TO NOTE

Wednesday, March 22 -- Symposium on "THE UNCONSCIOUS PATIENT IN THE EMERGENCY ROOM" at Sinai Hospital of Baltimore

Wednesday through Friday, May 3-5 -- Faculty's Annual Meeting, Civic Center, Baltimore

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# MEDICAL NEWS BRIEFS

## BLUE SHIELD SETS RECIPROCITY SYSTEM

A new system providing direct payment to physicians for treatment of out-of-state subscribers was instituted by Maryland Blue Shield on March 1. In order for a subscriber to be eligible for this system, his scope of coverage must meet certain criteria and payment must be on a usual and customary basis.

This new system, known as Blue Shield's Permanent Reciprocity System, will greatly ease the task of handling medical claims for out-of-state patients, it is claimed.

When a doctor provides service to a patient enrolled in a reciprocity benefit program in an out-of-state Blue Shield Plan, he will be able to bill and receive payment directly from Maryland Blue Shield.

Under this new program, a physician will receive his usual fee as determined by Maryland Blue Shield. This means that physicians' charges will be evaluated by Maryland Blue Shield based on a through knowledge of medical costs in the given area and specialty.

This means that the doctor will now only have to deal with Maryland Blue Shield. No longer will he have to contend with time-consuming problems of dealing with a plan in another part of the country and with unfamiliar Blue Shield claim forms.

Reports for all covered services will be made on Blue Shield claim forms currently in use. Physicians will be able to recognize those patients who are Blue Shield subscribers having this type of program by a special annotated Blue Shield subscriber identification card.

This special ID card bears a red arrow in the top left-hand corner. A series of three numbers preceded by the letter "N" appears within this printed red arrow. In addition, subscriber group and contract or certificate numbers are outlined in red.

When filing a claim for service provided a reciprocity-eligible patient, the physician need only fill out a Maryland Blue Shield claim form in the normal fashion, except that he must be sure to include the letter "N" and the three numbers that appear inside the red arrow in the space on the claim form marked "contract number" or "subscriber identification number."

To facilitate the handling of this type of claim by Blue Shield, all of the information bordered in red on the patient's ID card must be entered in the appropriate spaces on the claim form. The form should then be sent to Maryland Blue Shield along with other claim forms completed that day.

Blue Shield says these claims are processed immediately and the doctor is sent his usual, customary, and reasonable fee by Maryland Blue Shield.

Of primary concern to doctors is the fact that the patient who has this type of Blue Shield benefit program is fully covered for a wide range of services including surgery, anesthesia, radiation therapy, diagnostic X-ray, laboratory and pathology, in-hospital medical, and outpatient services. Claims for maternity services will not be included in the reciprocity system; they should be submitted directly to the patient's home plan.

Any questions on this new plan should be referred directly to Maryland Blue Cross and Blue Shield, 700 East Joppa Road, Towson, Md. 21204, phone 494-5800.

## METHADONE PROGRAM AIMS TO REHABILITATE ADDICTS

With the help of more than $200,000 in state and national grants, a methadone maintenance treatment program for heroin addicts is getting underway at the University of Maryland at Baltimore.

Leon Wurmser, MD, newly appointed as clinical director of drug abuse programs at the medical school, is in charge. The project will be operated in conjunction with Bon Secours Hospital. A widely respected psychiatrist, Dr. Wurmser formerly served as director of the drug abuse center at The Johns Hopkins Hospital.

Patients for the program will go through medical and psychological screening at Bon Secours. To be accepted, a person must have been addicted for at least three years, have no multiple addictions, and be physically and psychologically fit for treatment with methadone.

About 100 addicts can be accommodated on an outpatient basis at the treatment center, which will be located adjacent to the Tuerk House on Greene Street in Baltimore.

## BALTIMORE CANCER RESEARCH CENTER

The Baltimore Cancer Research Center of the National Cancer Institute advises that they accept patients with acute leukemia, lymphoma, brain tumor, and various types of metastatic solid tumors.

These facts are being brought to your attention inasmuch as they depend entirely upon practicing physicians to refer patients to them and their programs are apparently not well known to many physicians who might care to refer their patients.

They employ appropriate radiation therapy and/or the latest available cancer chemotherapy after extensive diagnostic procedures to assess tumor status. Considerable effort to improve biochemical assays for tumor diagnosis and for therapy follow-up is under way.

Supportive care programs include methods to prevent and treat infection and hemorrhage including liberal platelet transfusions, newer antibiotics, and extensive microbiologic surveillance.

Since improved survival in acute nonlymphocytic leukemia occurs only with a complete bone marrow remission, various intensive drug regimens are under study to attain that goal.

Laminar air flow facilities are being used to determine if a sterile environment plus endogenous microbiologic flora suppression will reduce the incidence of serious infections in patients with acute nonlymphocytic leukemia and hence improve the potential for attaining a complete bone marrow remission with cancer chemotherapy.

Patients with brain tumors unresponsive to further surgery or radiation are treated with new agents that cross the blood brain barrier. Programs for meningeal leukemia prophylaxis and therapy with the diagnostic aid of the cytocentrifuge have recently been initiated.

Patients with lymphosarcoma and Hodgkin's disease are treated with radiation or combination chemotherapy depending on the results of staging procedures including laparotomy and splenectomy.

Research laboratory facilities include biochemical studies of drug metabolism, enzymology, and microbiology.

Referred patients are evaluated and accepted for therapy if there is reason to believe they will benefit from therapy and have disease entities currently under study.

There is no charge to patients for hospitalization, medical services, or drugs. Patients are returned to their private physician or may be followed by the Center's physician in cooperation with the referring physician.

Inquiries are welcome and should be directed to Robert J. Esterhay, MD, Admitting Officer, Baltimore Cancer Research Center, 3100 Wyman Park Drive, Baltimore, Md. 21211, Tel. (301) 366-5573 or 338-1258.

## EAST BALTIMORE MEDICAL PROGRAM

More than 2,000 East Baltimore residents have enrolled in the East Baltimore Medical Program (EBMP) since it began delivering health services in November.

The new comprehensive, prepaid group practice health plan, operated jointly by The Johns Hopkins University and Hospital, and the East Baltimore Community Corp., Inc., emphasizes prevention of illness, early detection of disease, and ambulatory care.

EBMP provides a wide range of medical, dental, and hospital services including continuing maternity and family planning services, child care, prescription services, diagnostic services, vision and hearing services, nutritional counseling, health education, and drug abuse and alcoholism counseling to about 5,000 area residents. The program hopes to expand to include 25,000 East Baltimore residents.

Unlike most health service organizations, the EBMP is operated on a prepayment basis. This means a fixed amount is paid for each participant each month regardless of the medical care needed during that month.

Russell A. Nelson, MD, president of The Johns Hopkins Hospital, said that in order for this new program to be financed, a unique funding arrangement had to be negotiated with federal, state, and local welfare agencies.

After extensive negotiations, Dr. Nelson said many of these fragmented health services were merged into a contract with Maryland Medicaid that is unique in the country because it supports program members by awarding monthly capitation payments. (Normally, Medicaid pays only for health services already provided by physicians in hospitals and clinics.) Capitation payments range from $14 to $24 per person per month.

## DIABETICS MAY LIVE LONGER

At a recent AMA meeting in New Orleans, a team of physicians from the Georgetown University Medical School reported that many well-controlled diabetics — including those treated with controversial oral drugs—may live significantly longer than nondiabetics.

The study team was headed by James M. Moss, MD, and DeWitt E. DeLawter, MD—a Montgomery County physician and president-elect of Med-Chi.

According to an AP dispatch on the interview, their findings constitute the strongest challenge yet to a report 18 months ago by a government-supported private research group that cast suspicion on the safety of oral pills in treating diabetes. The government group had reported that oral drugs may do more harm than good when used as a substitute for insulin in moderately severe diabetics.

The Moss-DeLawter team said they had examined the records of 1,840 patients who developed diabetes between ages 37 and 70 and who had been under treatment from one to 15 years by diet, oral drugs, or insulin.

"The average longevity of these patients was 10% greater than would have been anticipated by life insurance tables of nondiabetics," they are reported to have said, and added: "There was no evidence that oral hypoglycemic, blood-sugar-lowering drugs have a deleterious egect upon the cardiovascular system."

## BLOOD TRANSFUSIONS

The nation's 5,800 community hospitals transfused almost three million units of blood during a recent six-month period, with 20.8% being supplied by the hospitals' own blood programs.

According to a survey conducted by the American Hospital Association, collections through American Red Cross centers continued to be the largest single source of blood for community hospitals, accounting for 40.5% during the six-month period January 1 to June 30, 1971.

Other sources included community blood banks (20.5%), commercial blood banks (13.6%), other hospital blood banks (1.7%), and other sources (2.9%).


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## STATE HOSPITAL RATES ANNOUNCED

The Maryland Department of Health and Mental Hygiene reports that approval has been received for the establishment of costs for care and maintenance for patients in state hospitals.

The maximum cost for care and maintenance for patients in psychiatric mental hospitals is $18.42 a day; the cost of those patients in institutions for the mentally retarded is $16.31; and the cost for patients in chronic disease hospitals is $36.30 per day.

The Division of Reimbursements, Department of Health and Mental Hygiene, is responsible for handling the reimbursement program for the mental, retarded, and chronic disease hospitals. Mental hospitals affected are Crownsville, Eastern Shore, Springfield, Spring Grove, and Clifton T. Perkins. Mentally retarded institutions affected include Rosewood, Henryton, and Great Oaks. Chronic disease hospitals affected are Deer's Head, Montebello, and Western Maryland.

The yearly determination, effective for the current fiscal year, is required by law, according to the announcement. The rate of reimbursement established for patients or legally liable relatives, however, is based on the individual ability to pay. The rate of reimbursement, therefore, may vary from nothing to the full per diem charge.

## MEDICARE RATES TO BE INCREASED

HEW Secretary Elliot Richardson has announced a new premium rate, effective July 1, for Part B of Medicare. The new rate will be $5.80 per month, up from the current $5.60.

Provisions of the Medicare law require an annual review of the cost of the medical insurance program. The law requires that a rate be set which would be sufficient to cover estimated expenses incurred during each premium period.

According to Mr. Richardson, the premium increase is the lowest in recent years and reflects savings attributable to the new Price Commission guidelines and to administrative actions taken by the Social Security Administration. Richardson pointed out that in the absence of wage and price controls limiting increases in physician fees to 2½% a year it would have been necessary to increase the premium to at least $6.

The medical insurance program supplements the basic hospital insurance part of Medicare by helping to pay doctor bills and a wide variety of other medical expenses in and out of the hospital. About 19.8 million people 65 and over are enrolled for this supplementary protection. Premiums are designed to cover half the cost with the other half coming from general federal revenues.

## STATE APPOINTS OCCUPATIONAL THERAPIST

A unique use of occupational therapy is being tried with the appointment of Miss Mary Young as occupational therapist for the Preventive Medicine Administration, Maryland Department of Health and Mental Hygiene, according to Benjamin White, MD, chief of that administration.

Miss Young will examine and attempt to identify those practices in the daily routine of living which may lead to health deterioration, as well as positive factors which provide a measure of therapy.

"I believe this is the first such occupational therapy appointment in the country," Dr. White said, "and it will bring to preventive medicine the skills of this discipline."

Miss Young is a registered occupational therapist who received her professional education in England and her MEd at East Carolina (NC) University, where she has also served as assistant professor in the School of Allied Health.


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# In acute gonorrhea

## (urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



**Sterile Trobicin®**
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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**Warnings:** Antibiotics used to treat gonorrhea may mask delay the symptoms of incubating syphilis. Patients should b carefully examined and monthly serological follow-up for least 3 months should be instituted if the diagnosis of syphilis suspected.

*Safety for use in infants, children and pregnant women has n been established.*

**Precautions:** The usual precautions should be observed wi atopic individuals. Clinical effectiveness should be monitored detect evidence of development of resistance of *N. gonorrhoea*

**Adverse reactions:** The following reactions were observe during the single-dose clinical trials: soreness at the injection si urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in norm human volunteers, the following were noted: a decrease in hem

# Trobicin®

## sterile spectinomycin dihydrochloride pentahydrate, Upjohn

## single-dose intramuscular treatment

**High cure rate:* 96% of 571 males, 95% of 294 females**
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

**Assurance of a single-dose, physician-controlled treatment schedule**

**No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed**

**Active against most strains of Neisseria gonorrhoeae in vitro** (M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1648-6

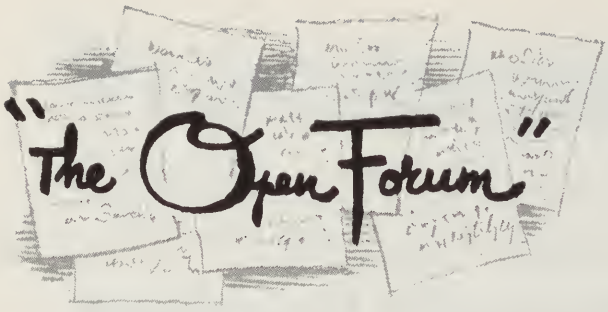
globin; hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.
*Male*—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
*Female*—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
*Susceptibility Powder*—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
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Evaluation was made of 150 Medicaid beneficiaries between 18 and 65, who presented themselves to a Baltimore Inner City physician's office for initial interview between May and November 1971. In addition to the immediate presenting medical history, inquiry was made why they or their spouses were unable to support themselves and had to rely on Medicaid. In addition, age, color, and education status were noted.

There were 98 females and 52 males in this group; 123 were white and 27 Negro. Age was distributed as follows:

| Age | No. |
|---|---|
| 18-28 | 71 |
| 29-38 | 29 |
| 38-48 | 28 |
| 49-58 | 16 |
| 59-65 | 6 |
| Total | 150 |

Eight finished high school, one has completed one year of college, and three are in school. The rest were dropouts.

Personal and Social background data could be grouped in 16 categories (see Table 1).

The present running battle between "bleeding hearts" and "get tough" advocates as to the solution of the problem of mounting indigent care costs makes the physician the whipping boy for the "exorbitant cost of medical care." Attacks upon physicians' probity, charity and competence continue to mount; newspapers print accounts of how much some physicians have netted in the previous year, etc.

One presidential candidate, noting "the quality of our health care delivery system is poor and deteriorating daily," indicts the system that is "Run for an by those, who PROFIT MOST from it—doctors, hospitals, etc."

The observations of this report tend to support those who would tighten up Medicaid eligibility procedures and institute active physical and psychiatric rehabilitation to lessen the health care burden.

To find "lost" husbands and "separated" marital partners in this day and age of all-embracing Social Security and advanced techniques of personal surveillance should not be impossible.

Energetic psychotherapy of those "too nervous to work," and compulsory work programs, such as those in New York State, might be of help to both the public purse and the patient involved.

**Table 1**

| | Cases | % |
|---|---|---|
| 1. Lack of rehabilitation after illness or injury, chronic voluntary invalidism, inertia and resignation | 29 | 19.5 |
| 2. Marital discord: separation of partners—often by mutual consent. No financial settlement: welfare agencies bear the burden of family maintenance | 18 | 12 |
| 3. Unwillingness, "nervous inability," lack of drive to do productive work, flight into babysitting or neurotic pseudo-invalidism | 17 | 11.4 |
| 4. Organic illness, brain damage, or handicap | 16 | 10.65 |
| 5. Husband left wife with small children, can't be found for purposes of supporting family—available for copulation, though | 14 | 9.3 |
| 6. Alcoholism | 11 | 7.3 |
| 7. Low salary, due to limited ability to earn. Poverty | 8 | 5.3 |
| 8. Single person with small children | 7 | 4.7 |
| 9. Unemployment, slack season, layoff | 6 | 4 |
| 10. Husband in jail—small children | 5 | 3.3 |
| 11. Drug addiction | 4 | 2.6 |
| 12. Mistakes of overzealous welfare department workers | 3 | 2 |
| 13. Patient in school | 3 | 2 |
| 14. Nicotine abuse | 2 | 1.35 |
| 15. Obesity | 2 | 1.35 |
| 16. Widow or divorcee keeps on having children | 3 | 1.35 |
| 17. Miscellaneous (Travelbugs, in service, just out of jail) | 2 | 2 |

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*Warnings:* Use during pregnancy is to be avoided.
*Precautions:* 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
*Adverse Reactions:* Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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**Contraindications:** Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

**Warnings:** Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

*Usage in Pregnancy:* In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

*Effect on PBI Determination and $I^{131}$ Uptake:* Isopropamide iodide may alter PBI test results and will suppress $I^{131}$ uptake. Substitute thyroid tests unaffected by exogenous iodides.

**Precautions:** Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

**Adverse Reactions:** Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

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# Call it what you will, it may be premalignant..

## Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



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# and Efudex® (fluorouracil) 5% cream can resolve it.

## Call it actinic, solar or senile keratoses, many regard it as "precancerous."[1,2]

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,[3,4] offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these mutliple lesions.

## Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.[5] Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.[6]

## Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.[5] The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.[6]

## How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

## Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

**References:** 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).




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*A Service of the Heart Association of Maryland*

**the heart page**

# Trifascicular Concept of Ventricular Activation

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Significant left axis deviation (LAD) of the mean QRS axis in the frontal plane of the electrocardiogram (ECG) is practically always due to a conduction abnormality.[1] The condition defect involves one of the two divisions, or fascicles, of the common atrioventricular (AV) bundle through which impulses travel to activate the muscle fibers of the left ventricle. A third division or fascicle of the AV bundle supplies the right ventricle.

In the normal heart, impulses leaving the AV bundle travel through all three fascicles very rapidly and activate the anterior and posterior portions of the left ventricle and the entire right ventricle almost simultaneously so that ventricular activation is completed in about 0.05 to 0.06 second. However, block in impulse transmission through the fascicle to the anterior portion of the left ventricle results in an asynchronous and prolonged sequence of activation of the left ventricle. This is illustrated schematically in Figure 1. When the anterior fascicle (AF) is blocked, the impulse passes through the posterior fascicle (PF) activating that portion of the left ventricle, then passes through peripheral Purkinje fiber connections to spread to the anterior portion of the left ventricle slightly later.

This causes a slight prolongation of left ventricular activation and the QRS duration measures about 0.08 to 0.09 second. Since the impulse stays within the conduction system, marked prolongation (greater than 0.12 second) of the QRS does not result. In addition to being slightly prolonged the pattern or axis of the QRS is altered because of the asynchronous activation. Initially, a brief rightward and inferiorly directed vector force results in a small, short Q wave in leads I and AVL of the ECG. This is followed by a longer, larger vector directed leftward and superiorly (bottom left of Figure 1). This late vector results in a tall R wave in lead I, but a deep S wave in leads II and III (bottom right in Figure I). The ECG pattern is that of left axis deviation with the mean axis being at about minus 60 degrees.

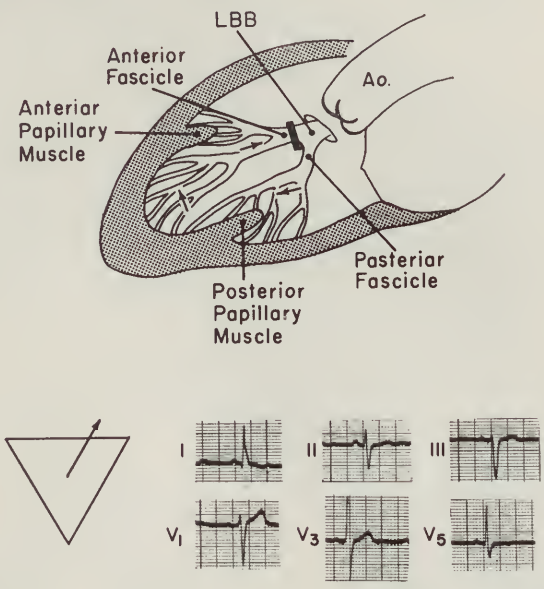



Figure 1: Left anterior hemiblock resulting in delayed activation of the anterior and superior surface of the left ventricle.

Clinical–pathologic correlations and left ventricular intracardiac electrograms (his bundle recordings) have shown that LAD of minus 30 degrees and beyond is practically always due to a conduction defect in the AF. An axis between zero and minus 30 degrees (horizontal axis) is often due to the same conduction defect but may also be seen in obese or pregnant patients without conduction defects.

Thus, the three features of block of impulse transmission through the anterior fascicle of the conduction system of the left ventricle are: 1) small, brief Q wave in leads I and AVL (less than 0.02 second); 2) prolongation of the QRS duration to 0.08 or 0.09 second; and 3) deviation of the mean QRS axis to or beyond minus 30 degrees. These ECG features have been termed "left anterior fascicular block" (LAFB), "left anterior hemiblock", or "left anterior-superior parietal block."

The conduction defect is due to degeneration[2] or fibrosis[3] of the fibers of this fascicle. The cause of the degeneration is uncertain. Fibrosis of the fascicle often occurs in a patient with left ventricular hypertrophy due to hypertension or aortic valve disease. The LAD is not due to the left ventricular hypertrophy, but rather to the fibrosis of the anterior fascicle. Occasionally the anterior fascicle may be blocked as a consequence of a myocardial infarction. In this case the Q wave in leads I and AVL may be deep and wide (0.04 second). This has been termed anterior peri-infarction block.[4]

Block of the posterior fascicle of the LV, left posterior fascicular block (LPFB), results in activation of the LV in a sequence just the opposite to that seen in LAFB. There is a small Q wave in leads II, III, and AVF, prolongation of the QRS, and deviation of the mean frontal axis inferiorly and rightward (S wave in lead I and tall R wave in leads II, III, and AVF).

Block of the fascicle to the right ventricle results in the familiar right bundle branch block of the ECG with a QRS of 0.12 second or greater duration and a RsR' or RR' wave in lead V-I.

When block occurs in any two fascicles the resultant ECG pattern is termed bifascicular block. Specific ECG patterns have been detailed by Rosenbaum[1] which allow the identification of the three possible bifascicular blocks. Though often a harbinger of complete or trifascicular heart block, an artificial pacemaker should not be inserted unless the patient is symptomatic with syncopal or near-syncopal episodes.

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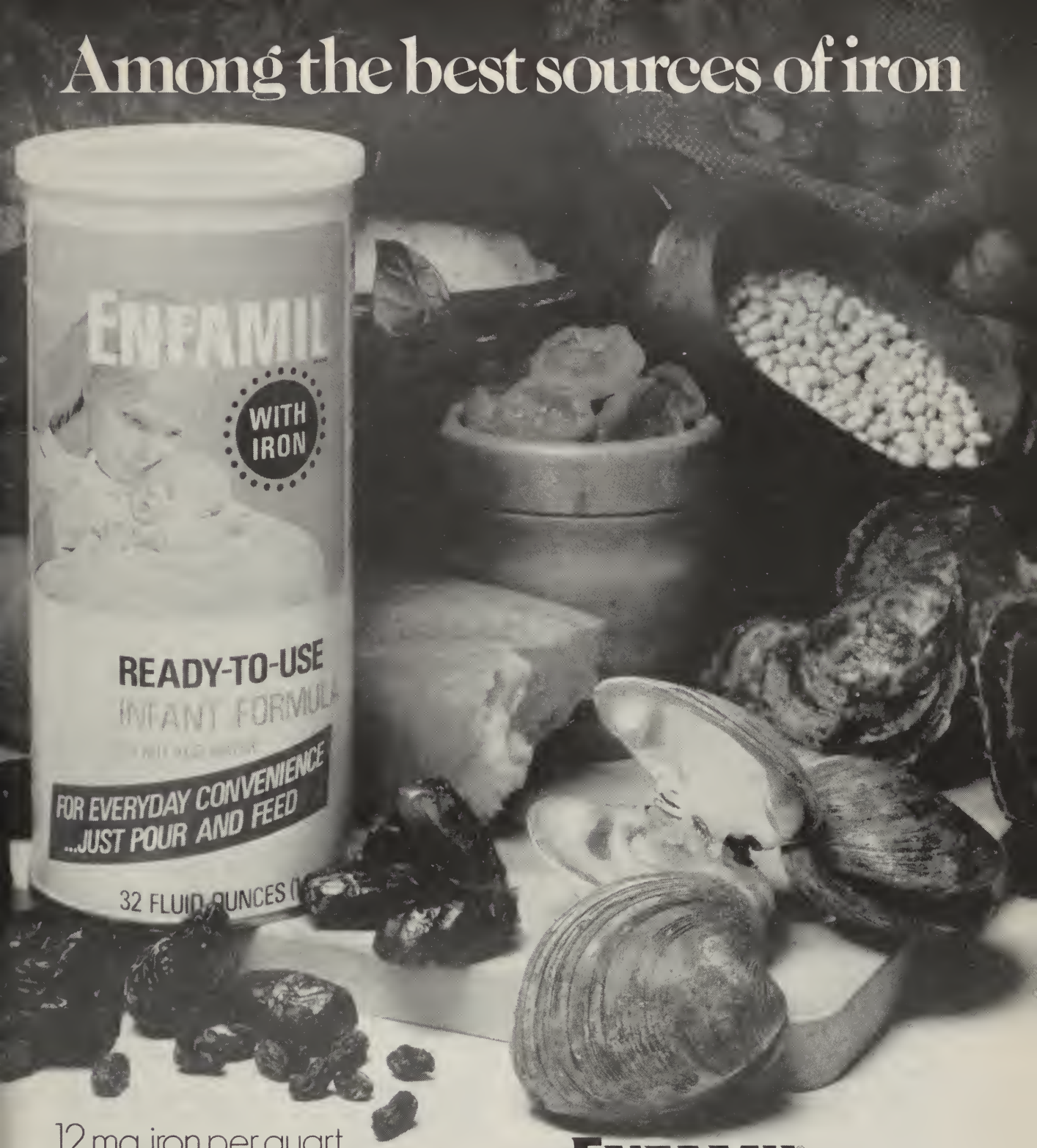

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# A Study of Women Who Discontinue Family Planning Clinic Attendance

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GARY R. SNYDER, MD (2)
J. KING B. E. SEEGAR, JR., MD (3)

Many of the original problems which faced the early promoters of family planning have been substantially reduced. Resistance to offering family planning assistance as a public health service has decreased.[1] More efficient and less expensive contraceptive techniques have become available.[1] Computerized data systems capable of accurately monitoring family planning activity have been described.[2] Two major problems remain: recruiting women to accept family planning, and maintaining interest in continued use of contraception except when children are desired. This paper focuses on the group of women who discontinue attendance at a family planning clinic.

Maryland has a statewide family planning program with a computerized data system which maintains and constantly updates social, demographic, medical, and clinic attendance information.[2] If a woman informs her clinic that she is withdrawing from the program, or if a public health nurse can contact and question the woman who stops attending, then the records can be completed, and should include the reasons for termination. However, if a woman simply stops attending and cannot be located by a public health nurse, then her reasons for dropping out of the program are unknown. The purposes of this study were to locate and interview as many of the women as possible who had dropped out of the family planning program for unknown reasons ("inactives"), compare their epidemiologic characteristics with those who continued to attend the clinic regularly ("actives"), determine their motives for stopping clinic attendance, and to learn whether they had actually stopped using contraception or had merely ceased using the clinic as their source.

## Methods

One county in Maryland was selected as the study area. This county was chosen prior to examining any of the data; thus, this county may not be representative of the state as a whole, but there was no preselection bias. The population designated inactive for this study were all women on oral contraceptives who were more than 30 days late for their appointment in the clinic, plus all women on any other form of contraception who were more than 90 days late for their appointment. Those who had notified the clinic that they were quitting the program (eg, moving or wanting a pregnancy) were not included.

The study consisted of two parts. The first was a comparison of the inactives with the actives using the social, demographic, medical, and atten-

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(3) Chief, Maternity and Family Planning Section, Division of Maternal and Child Health, Maryland State Department of Health and Mental Hygiene.

dance data available from the computerized records. The second aspect of the investigation was a personal interview with all the inactives who could be located. Attempts to find these women included sending letters, telephoning, talking with landlords, employers, finance companies, friends, relatives, and neighbors. A printed questionnaire was used as a guide and was administered in the woman's home by the same interviewer in all cases. At least five attempts to find these women at home, including both daytime and evening visits, were made for each inactive. All data were compared using the chi-square test, and differences with a $p<0.01$ were considered significant.

## Results

The study county had 583 women on the clinic roster. Of these, 58 (10%) were inactive as defined above (Table 1). There was no significant difference between the inactives and the actives in age, race, religion, school grades completed, source of payment, travel time to the clinic, number of children, number of births of babies less than 5 lb. 8 oz., number of fetal deaths, number of children wanted, or method of contraception. The two categories in which the inactives varied significantly from the actives were marital status (Table 2) and number of pregnancies (Table 3). The inactive population included a higher percentage of single (19% vs 11%) and separated (9% vs 2%) women, whereas a comparatively greater percentage of the active group was married (85% vs 69%) (Table 2). The inactives had had significantly fewer pregnancies (15% with four or more) than the actives (30% with four or more) (Table 3). In addition to these differences, it was noted from the records that 25 (43%) of the inactives had made only one visit to the clinic and then never returned.

**Table 1: Inactive Patients as of April 25, 1969 by Length of Time Inactive**

| | Number of months late | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | >9 | Total |
| Number and | 7 | 15 | 8 | 5 | 11 | 4 | 2 | 4 | 2 | 58 |
| percent of inactives | 12 | 26 | 14 | 9 | 19 | 7 | 3 | 7 | 3 | 100 |

**Table 2: Inactives Compared With Actives by Marital Status**

| | Marital Status | | | | | |
|---|---|---|---|---|---|---|
| | married | single | widowed | divorced | separated | total |
| Number and | 40 | 11 | 0 | 2 | 5 | 58 |
| percent of inactives | 69 | 19 | 0 | 3 | 9 | 100 |
| Number and | 446 | 58 | 2 | 7 | 12 | 525 |
| percent of actives | 85 | 11 | <1 | 1 | 2 | 100 |

$X^2 = 13.3$; d.f. $= 4$; $p < 0.01$

**Table 3: Inactives Compared With Actives by Number of Pregnancies**

| | Number of Pregnancies | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | >5 | Total |
| Number and | 4 | 18 | 14 | 13 | 4 | 2 | 3 | 58 |
| percent of inactives | 7 | 31 | 24 | 22 | 7 | 3 | 5 | 100 |
| Number and | 15 | 123 | 139 | 101 | 65 | 37 | 56 | 525 |
| percent of actives | 3 | 23 | 26 | 19 | 12 | 7 | 11 | 100 |

$X^2 = 18.2$; d.f. $= 6$; $p < 0.01$

Of the 58 women listed as inactive, 38 were located and interviewed. Of the remaining 20 women, five were contacted but refused to be interviewed, three had moved out of the state, three had moved with no forwarding address, one was in a mental institution, and eight were never found at home. There was no significant difference between the interviewed inactives and the noninterviewed inactives in age, race, religion, school grades completed, source of payment, travel time to the clinic, number of pregnancies, children, births of babies less than 5 lb. 8 oz, fetal deaths, number of children wanted, marital status, method of contraception, or length of time since last clinic visit.

The first part of the interview was an exact duplication of the questions asked in the clinics and recorded on the computer printouts. The answers, with one exception, were very much in agreement for the demographic and social history, indicating a high degree of reproducibility. The exception was the response to the question of how many more children were desired. Only 22 (58%) of the interviewed women gave the same answer at the time of interview as they had at their last clinic visit.

The second part of the interview dealt with the reasons for and the consequences of their dropping out of the program. Nineteen (50%) of the women interviewed were no longer using the method of contraception they had been using on their last clinic visit (Table 4). The changes in method of contraception from oral to other forms were a result of side effects or apprehension concerning possible effects (eg, fear of can-

**Table 4: Contraceptive Methods of Interviewed Inactives at Last Clinic Visited Compared With Method at Time of Interview**

| | Contraceptive Method | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | oral | I.U.D. | foam | abstinence | other* | none | pregnant | total |
| Number and percent at last visit | 34<br>89 | 3<br>8 | 1<br>3 | 0<br>0 | 0<br>0 | 0<br>0 | 0<br>0 | 38<br>100 |
| Number and percent at interview | 15<br>39 | 3<br>8 | 6<br>16 | 3<br>8 | 6<br>16 | 2<br>5 | 3<br>8 | 38<br>100 |

$X^2 = 24.9$; d.f. = 6; p 0.005

*other = condom, douche, withdrawal, and rhythm

cer). Three (and probably four) women who had stopped all contraception were pregnant (only one of these was planned).

A series of open-ended questions concerning reasons for not continuing with the program and suggestions for improving the clinics drew numerous and diverse responses. Two comments however appeared repeatedly. Eight women (21%) desired different clinic hours (evenings or Saturdays). Fifteen women (39%) felt their waiting time in the clinic was too long. The waiting times at their last clinic visit as reported retrospectively by the women at the time of interview ranged from 15 mintues to more than five hours (mean = 2½ hours).

## Discussion

A main finding of this study is the low rate of discontinuance of contraception among the women who stop attending the family planning clinics. Ten percent of the clinic population was inactive with respect to attendance. But the majority of these women were still using contraception (Table 4) either from the clinic (eg, an I.U.D. still in place, but the woman was not bothering with routine checkups), or from another source (eg, hospital, private physician, or pharmacy). The shift from oral contraception to other forms (Table 4) was due either to side effects or apprehension concerning possible effects. Only five (1%) of the total clinic population were using no contraception at all. The inactives reported one planned pregnancy and two, possibly three, unplanned ones.

Although most women were still using some form of contraception, the fact remains that there were several unplanned pregnancies among the inactives and a few other women were using unreliable contraceptive methods. Since this study indicates that the inactives have a history of fewer pregnancies, a greater percentage are unmarried, and 43% made only one visit to the clinic and never returned, we can conclude that more attention should be given **initially** to women with few pregnancies and those who are unmarried. The lack of evening or Saturday clinics and the long waiting periods were frequently mentioned by the inactives as problems with the family planning program. Correction of these situations might also help decrease the percentage of inactives.

## Summary

A study was made of women in the Maryland Family Planning Program who had become inactive. The inactives differed significantly from the active clinic population in marital status (more singles) and number of pregnancies (fewer). A majority of the inactives were still using some method of contraception. The two major problems with the clinics, according to the inactives, were the lack of Saturday or evening clinics and the long waiting periods in the clinics.

## ACKNOWLEDGEMENTS

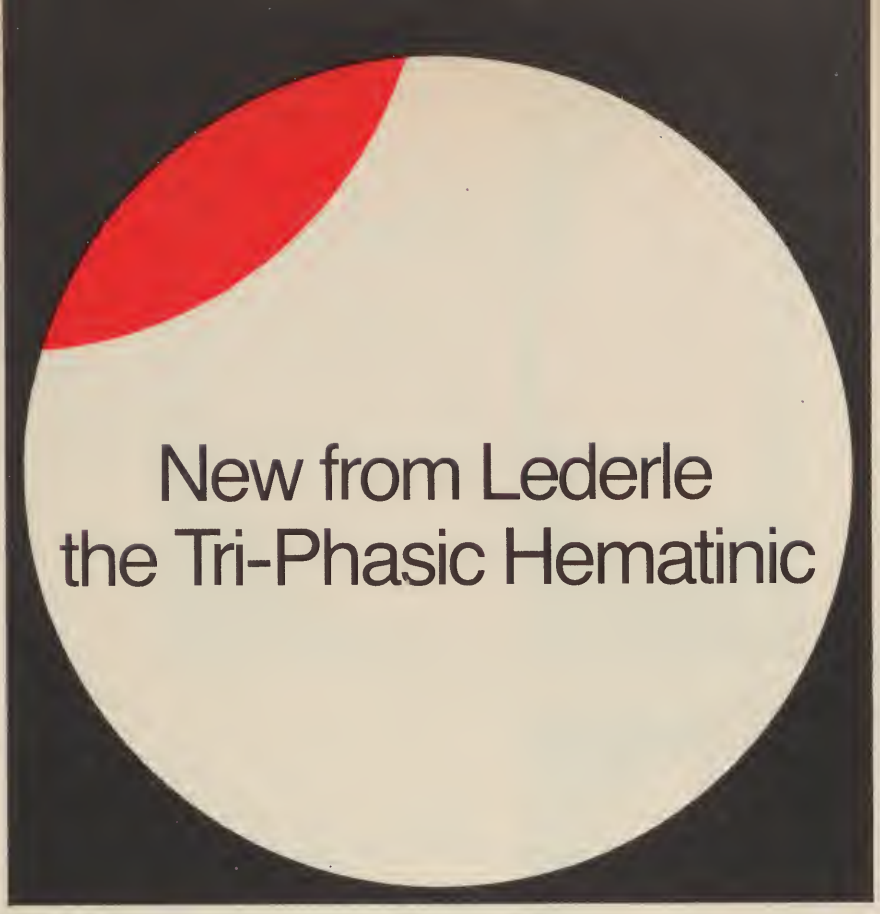
The cooperation of John L. Pitts, MD, Chief, Division of Maternal and Child Health, Maryland State Department of Health; the Baltimore County Health Department; and the Howard County Health Department is greatly appreciated. Peter B. Tamblyn, MPH, Public Health Advisor, NCDC; Frances Porcher, NCDC; and Carl W. Tyler, Jr., MD, Chief, Family Planning Evaluation Activity, NCDC, furnished valuable support and suggestions.

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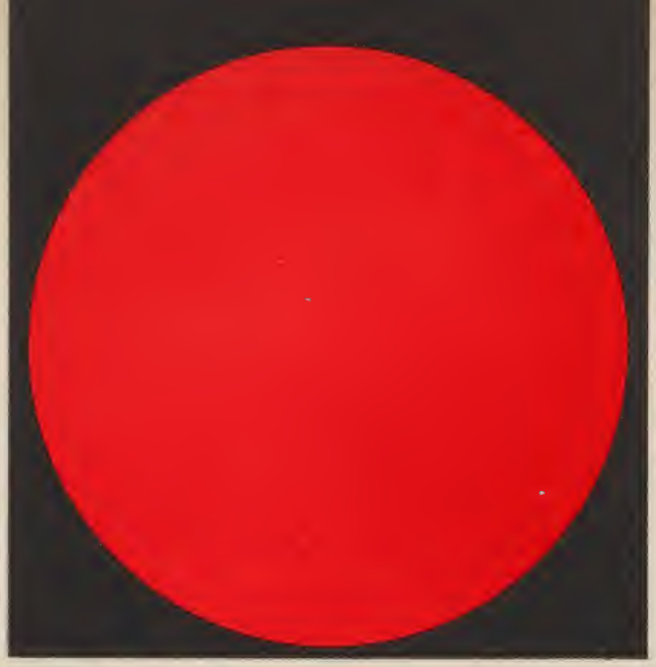
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**THE TRUTH ABOUT WEIGHT CONTROL, by Neil Solomon, MD, with Sally Sheppard, Stein and Day, New York City, 1971.**

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**LUMBAR DISC DISEASE, by Blaine S. Nashold, Jr., MD, and Zdenek Hrubec, ScD, The C.V. Mosby Company, St. Louis, 1971.**

This "report," as it is described in the preface, was written not only for the specialist in this field but for the general practitioner as well. The summaries at the end of each chapter and the final summary are so organized that they may be used as a guide for the clinical evaluation of the patient with lumbar disc disease. For this end alone, it should be a valuable addition to any physician's library.

**REGISTRY OF PRIVATE SCHOOLS FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS, National Educational Consultants, Inc., Baltimore, Md., 1971.**

This immense book was published to fill a long-felt need by placing in one location a listing of all educational facilities for those children who have needs beyond the normal educational ones.

It is in a format that makes for easy reference, not only by indexing the schools by disabilities, but listing them by state and area as well. This presents a major reference tool for medical and hospital libraries as well as major public and school libraries.

**INSTRUCTIONAL COURSE LECTURES, the American Academy of Orthopedic Surgeons, The C.V. Mosby Company, St. Louis, 1971.**

This is Volume XX of these lectures and is a selection of those papers presented at the annual meeting of the Academy in January of 1970. Emphasis has been placed on the selection of well-rounded and diversified subject material representing the various spheres of the art of orthopedic surgery. The aim of this book is to present the current state of knowledge in a given subject and it does this well.




**APPROACH TO THE MEDICAL CARE OF THE SICK NEWBORN, by Sophie H. Pierog, MD, and Angelo Ferrara, MD, The C. V. Mosby Company, St. Louis, 1971.**

This book, perhaps, marks a first in this field, for it attempts to cover the organization and dynamics of newborn services as well as all facets of care of the newborn-at-risk. It is an excellent text and one well worth while for all categories of physicians — the pediatric house officer in training, the pediatrician, and the family practitioner. The hospital administrator would also benefit from the section dealing with the organization and dynamics of newborn services. In short, we think it a worthwhile book to purchase for any medical library.

**LASERS IN MEDICINE, by Leon Goldman, MD, and R. James Rockwell, Jr., Gordon and Breach, New York, 1971.**

In this book the authors have reviewed the extensive and detailed work of the entire staff of the Laser Laboratory, Medical Center of the University of Cincinnati. Surgeons, dermatologists, histologists, and histochemists are only a few of the persons who have contributed to this publication which ranges the entire gamut from A to Z of laser use in medical matters. It is a new book and one that for the first time puts most of current laser technology in one place.

**CURRENT DIAGNOSIS AND TREATMENT, by Marcus A. Krupp, MD, and Milton J. Chatton, MD, and associated authors, Lange Medical Publications, Los Altos, Calif., 1972.**

Most physicians will probably purchase this softcover book for use as a desk reference on the most widely accepted techniques currently available for diagnosis and treatment. It is not intended to be used as a textbook of medicine and has current references, where appropriate, to the clinical literature and general bibliographies for further study or reference. This book represents an up-to-date tool for the busy physician and one that he can use almost every day.

# PEER REVIEW

The State of Maryland's Medical and Chirurgical Faculty established a Peer Review Committee in 1970, with a mandate to review the appropriateness and quality of the medical care given by Maryland physicians. The members of the Committee, all practicing physicians from the Faculty, have worked over the last year to determine how best to carry out the function of Peer Review and have, over this time, reviewed a number of cases. Since one of the major functions of the Committee is education, it seems worth while to use THE JOURNAL to present typical cases seen by the Peer Review Committee.

A recent case, brought to the attention of the Committee by a local health officer, exemplifies a number of professional and legal issues. The health officer had received and investigated a complaint from a relative of a nursing home patient. The relative alleged that mismanagement of care by the physician had led to the death of the patient. The health officer's review of the nursing home records indicated the patient was 80 years old at the time of his death and had been in the nursing home for seven years as the result of a stroke.

The patient had been known to have extremely sensitive skin prone to blistering; this condition was under treatment by the physician at the nursing home. The patient's relatives had made no complaints on his care and treatment up until shortly before his death in March 1971. According to the records, in early January the nurse in attendance noticed an inflammation on the leg accompanied by a fever. She requested that the physician visit the patient at that time. The first relevant order for medication by the physician came in early January, 25 days after the nurse's request. Although there are several doctor's visits recorded in early January, there is a six weeks' hiatus in recorded visits until late February. Throughout this period the patient's condition had deteriorated and gangrene had infected the leg. The patient was sent to surgery in early March and died a few days later.

On the basis of his investigation the health officer asked the Peer Review Committee if it would be appropriate for the Committee to look into the matter. The Committee agreed and requested copies of the records and an interview with the physician in question. During the interview, held at one of the regular meetings, the physician stated that, because of his busy schedule, he often did not record all visits with his patients. He had, he said, visited the patient in question several times and was fully aware of the patient's condition and decline. He further stated that it was not uncommon for physicians not to record visits to nursing homes. He felt the relative was being unfairly critical of what he considered generous and adequate treatment rendered to the patient. He agreed however that from the records it was impossible to determine that he had rendered such care.

The Committee was understanding of the physician's position in handling both his busy practice and his work in the nursing home. The Committee however felt it could not condone the physician's practice of not recording any and all visits made to his patients. The physician was instructed on the importance of his responsibility to keep such records and not assume that someone else might record them. Without well documented records there was poor evidence of adequately administered treatment if questions should arise.

The implication of this particular case to the general membership would seem to be that the physician who gives adequate care without properly recording such care, even when such inadequate recording seems to be the rule rather than the exception, is both leaving himself indefensible against subsequent legal action and is not functioning under what is considered adequate medical standards.

RICHARD C. ARBOGAST, MD
Member, Peer Review Committee





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MRS. WALLACE H. SADOWSKY, EDITOR



# DOCTORS' DAY
# March 30, 1972

The Woman's Auxiliary to the Medical and Chirurgical Faculty will join with other medical auxiliaries throughout the nation to observe Doctors' Day on March 30.

Each year, at the request of the Auxiliary, the Governor of Maryland issues a proclamation praising Maryland physicians and their allied personnel for their outstanding work and skills in both preventing and curing ills, as well as for developing and disseminating advanced knowledge in medicine and surgery.

The first Doctors' Day observance was held by the Barrow County (Ga.) Auxiliary on March 30, 1933. The date of March 30 was not chosen at random, but to commemorate one of the greatest discoveries in medical history. It was on this date in 1842 that Dr. Crawford W. Long, a famous Georgia physician, first used ether as an anesthetic agent in a surgical operation, thereby providing mankind with the blessedness of freedom from pain and suffering during surgery.

In their first observance of Doctors' Day, the Barrow County Auxiliary mailed cards to the doctors and their wives, placed flowers on the graves of deceased doctors (Dr. Long included), and concluded the ceremonies with an elegant four-course dinner at the home of Dr. and Mrs. William Randolph, with appropriate toasts, tributes and responses, and the hope that Doctors' Day would continue to be observed on March 30 each year.

In 1935 the Woman's Auxiliary to the Southern Medical Association adopted Doctors' Day, March 30, at the suggestion of a physician's wife in Georgia, Mrs. Charles B. Almond, that this date be observed annually to honor members of the medical profession, both living and dead, with some act of kindness, gift or tribute in remembrance of these men and women, who by daily devotion to their duty of service to humanity, minister to our health and welfare.

The red carnation is the symbol of Doctors' Day and was adopted by the Auxiliary as the official flower in 1949. Each of the component Maryland auxiliaries celebrates Doctors' Day. The physicians in our state are honored in many different ways. Some are presented with carnations to wear; others receive red carnations placed in bud vases for their offices. Bowls of red carnations, along with posters explaining Doctors' Day, are placed in hospital and nursing home lobbies. In hospitals, cards embossed with red carnations are placed on the patients' meal trays. Medical books are given to hospital libraries and nursing schools. Exhibits are placed in libraries to commemorate Doctors' Day. Contributions are made to the American Medical Association Education and Research Foundation in honor of physicians. Recognition of the tribute paid to our physicians is publicized by newspapers, radio, and television.

In addition, many component auxiliaries hold dances, and dinner and theatre parties to further extend the commemorations in a social atmosphere.

Mrs. William P. Iames of Cumberland is Auxiliary State Chairman for Doctors' Day; she feels "that these tokens of appreciation are only trivial to the services rendered each year by our nation's doctors."

*"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."*

*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

**rehabilitation medicine**

# THE EFFECT OF STROKE ON WELL-ESTABLISHED RHEUMATOID ARTHRITIS

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*Supported in part by U.S. Department of Health, Education, and Welfare Health Services and Mental Health Administration Regional Medical Programs #5-032-A-1.*

## Introduction

Rheumatoid arthritis and hemiplegia are relatively common diseases, but the coexistence of the two conditions is rarely seen in the same patient. A few cases have been reported of patients with hemiplegia who later developed rheumatoid arthritis. In these cases the usual articular and periarticular manifestations of rheumatoid arthritis involved almost entirely the nonparetic side, suggesting a "protective effect" on the weight bearing and nonweight bearing joints of the hemiplegic side.[1-4] A review of the literature reveals but a single case report of a patient with rheumatoid arthritis who later developed a stroke.[5] Exacerbation of arthritis involving only the joints of the paralyzed limbs was described.

The present report describes another patient who developed hemiplegia years after the diagnosis of rheumatoid arthritis. Over the subsequent years, changes were noted in the subcutaneous nodules, in the degree of ulnar deviation, and in the relative severity of radiographic findings on the two sides. In this patient the paretic side showed less arthritic involvement than the other side.

## Case Report

S.V., a Negro housewife, was first seen at the Sinai Hospital of Baltimore in July 1965 at the age of 62. Thirty years previously, she had noted pain and swelling in the hands, wrists, shoulders, and knees. This improved and she was free of joint symptoms for about 20 years. In 1952 she was hospitalized in another hospital where an abdominal hysterectomy, bilateral salpingo-oophorectomy, and radium implantation of the cervix were performed for histopathologically proven cervical carcinoma. In 1956 a diagnosis of classical rheumatoid arthritis was made on the basis of constitutional symptoms, synovitis in the proximal interphalangeal joints of both hands, wrists, elbows, knees and feet, and typical rheumatoid nodules on both elbows. Morning stiffness of several hours duration was present. Since 1958 she had been moderately incapacitated and had developed deformities in both hands, wrists, and elbows. She was known to have hypertension, and for the past ten years received antihypertensive medication. She was treated with salicylates for arthritis.

In December 1962 she suffered a stroke which resulted in right hemiparesis. She was treated at home and slowly improved. There was some residual weakness in the right lower extremity and greater weakness in the right upper extremity, with a relatively nonfunctional hand and wrist and flexor spasticity. Three years later it was observed that the patient had complete disappearance of the articular manifestations in the joints of the right upper and lower extremities on the hemiparetic side, as well as decrease in the size of the subcutaneous nodule of the right elbow. She complained of continuous stiffness in the right (spastic) hand and morning stiffness of approximately two hours duration in the left hand.

On examination in 1965, her pertinent physical findings were limited to the motor impairment of the right hemiparetic extremities and to the clinical changes of arthritis on the left nonhemiparetic side. The right hand had no evidence of joint inflammation, although it was held in mild flexion at the wrist and fingers and




Figure 1: Left hand (non-paralyzed) shows ulnar deviation. The periarticular osteoporosis at the MCP joints and involvement of the carpal joints are more marked on the left.

Figure 2: Lateral projection of elbows, showing a narrow joint space on the left (non-paralyzed side) only. The outlined subcutaneous nodule over the left olecranon is larger than that on the right.

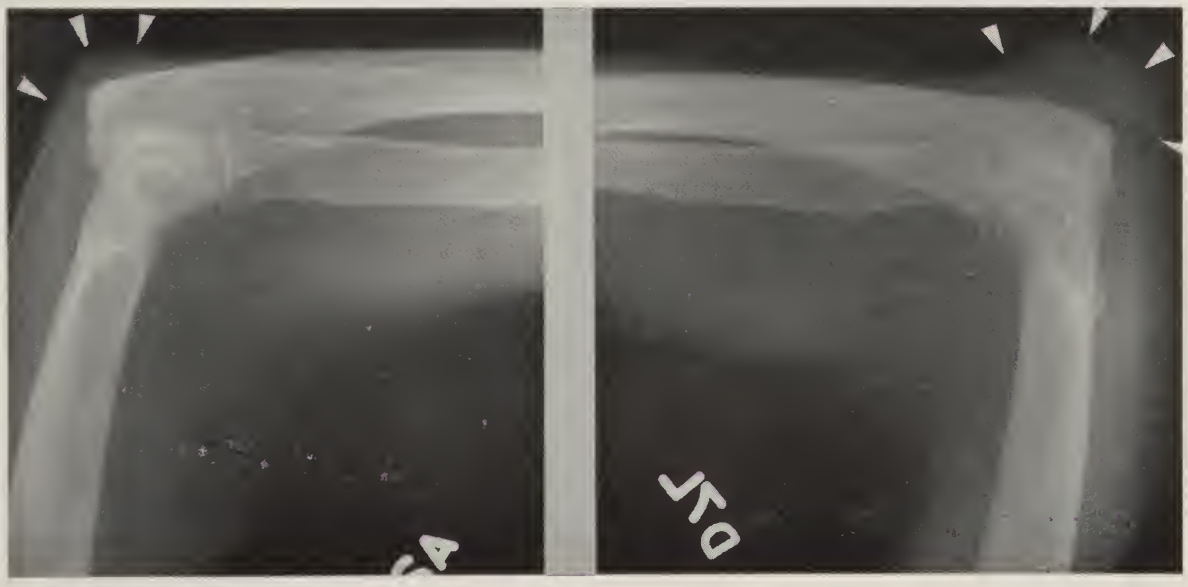




Figure 3: Pelvis, showing unilateral involvement. Left hip: narrowing of the joint space and protrusio acetabuli. Right hip: normal (paralyzed side).

was incapable of performing skilled movements. The left hand revealed fusiform enlargement of the proximal interphalangeal joints, swelling of the metacarpophalangeal joints, and ulnar drift. There were periarticular osteoporosis and juxtaarticular erosions of bone in both hands, but more severe on the left (Fig 1). Ulnar deviation of the second through fifth fingers was present in the left hand, while the fingers on the right were in good alignment. Signs of inflammation and moderate limitation of motion were present on the left in the wrist, elbow, knee, and ankle. She denied joint pains and had no evidence of synovitis in the joints of the right upper and lower extremities. She stated that the nodule on the right elbow was getting smaller. There was narrowing of the joint space and a huge subcutaneous nodule on the left elbow but a much smaller nodule on the right elbow (Fig 2). X-rays of the pelvis showed narrowing of the joint space, degenerative changes, and protrusio acetabuli (Otto pelvis) on the left, and a normal hip joint on the right (Fig 3). She had generalized distal muscle weakness and atrophy; they were more pronounced on the left side. She had a spastic-hemiplegic gait and a right foot drop. The biceps, triceps, quadriceps, and Achilles tendon reflexes were hyperactive on the right and hypoactive on the left.

Laboratory examination revealed normal or negative values for the white blood cell count, platelet count, urinalysis, blood urea nitrogen, uric acid, blood sugar, antinuclear factor, and L.E. cell preparation. Other results were: hematocrit 44%, erythrocyte sedimentation rate 33 mm/hr, total serum proteins 5.1 Gm%, albumin 3.2 Gm%, globulin 1.9 Gm%, and positive rheumatoid factor test (latex fixation titer, 1:512).

She was started on indomethacin and on a program of hydrotherapy, strengthening exercises, and gait training. There was some improvement in her functional status.

## Comments

A "protective" effect of a lower motor neuron paralysis due to poliomyelitis and peripheral nerve injuries has been reported in patients who subsequently develop either rheumatoid arthritis[6,7] or Heberden's nodes.[8] A similar protective effect of a stroke has been described in the joints of the paretic side in patients with rheumatoid arthritis[1-4] and Heberden's nodes.[9, 10]

The first case of a patient with hemiplegia who subsequently developed rheumatoid arthritis was published in 1953—a 53-year-old man in whom a diagnosis of right hemiplegia was made at the age of two. Forty-nine years later he developed severe unilateral rheumatoid arthritis and the joints involved were restricted to the "nonhemiplegic" side.[1]

Six other cases have recently been reported[2-4] which support the hypothesis of a protective effect of hemiplegia in the affected joints of the hemiplegic limbs, although in some instances

**Table 1: Summary of Reported and Present Cases**

**A. Cases of Hemiplegia, Followed by Rheumatoid Arthritis**

| Author and Year | Age at Report (Yrs) | Age at onset and Location of Hemiplegia | Interval between hemiplegia and R.A.*; Joints involved | Characteristic X-ray Changes of R.A.* | R.F.** | Subcutaneous Nodules |
|---|---|---|---|---|---|---|
| Jacqueline (1953) | 53 Male | 2 Right hemiplegia | 49 years later Left hand, wrist, elbow, knee, ankle & foot | Left hand | N.S.*** | N.S. |
| Thompson and Bywaters (1962) | 58 Male | 47 Right hemiplegia | 15 months later Left hand, wrist, elbow, shoulder, knee, ankle | Left hand and wrist | + | Left hand and elbow |
| | 71 Female | 65 Left hemiplegia | 2 years later Right hand, wrist, elbow, hip, knee, ankle, foot, left knee (slightly) | Right hand and patella | + | N.S. |
| | 63 Male | 29 Left hemiplegia | 32 years later Right hand, wrist, shoulder, knee, ankle | Right hand, knee, and foot | + | Right ankle and foot |
| | 49 Female | 36 Left hemiplegia | 6 years later Right hand, elbow, shoulder, knee — Left ankle (mild) | Right hand and elbow | + | N.S. |
| Barcelo & Adams (1965) | 53 Male | 50 Right hemiplegia | 6 months later Left hand, wrist, elbow, shoulder, knee, ankle, foot | Left hand and wrist | — | N.S. |
| Bland & Eddy (1968) | 50 Female | 37 Left hemiplegia | 5 months later Right hand, wrist, elbow, shoulder, knee, ankle, foot | Right hand and wrist | — | Right forearm |

**B. Cases of Rheumatoid Arthritis Followed by Hemiplegia**

| Author and Year | Age at Report (Yrs) | Age at onset and Location of R.A.* | Interval between R.A. & hemiplegia; findings | Characteristic X-ray Changes of R.A.* | R.F.** | Subcutaneous Nodules |
|---|---|---|---|---|---|---|
| Nava (1953) | 62 Female | Not specified, Chronic symmetric Rheumatoid Arthritis | Several years later Left hemiparesis and exacerbation of arthritis on the left | N.S. | N.S. | N.S. |
| Present Case | 65 Female | 53 Symmetric polyarthritis | 6 years later Right hemiparesis & remission of arthritis on the right | Primarily on the left hand, wrist, and hip | + | Both elbows (L R) |

*R.A. — Rheumatoid Arthritis

**R.F. — Rheumatoid Factor

***N.S. — Not Stated

findings of mild arthritis were noted in the joints of the hemiplegic side (Table 1-A).

One case was reported from Brazil[5] of a female suffering initially from typical bilateral and perfectly symmetrical chronic rheumatoid arthritis of several years duration. Subsequently at the age of 61, she developed left-sided hemiplegia followed by an acute exacerbation of arthritis involving only the joints on the left or "hemiplegic" side (Table 1-B).

This case, as far as we know, is the first of its kind: a patient with classical rheumatoid arthritis of six years' duration who then had a cerebral vascular accident with amelioration of her arthritis on the hemiplegic side. This effect was manifested by remission of the articular process and almost complete disappearance of the subcutaneous nodule. In the opposite "nonhemiplegic" side, slow progression of the rheumatic disease was clearly demonstrated, with chronic

active synovitis, increased bony lesions (erosions, subluxations, and protrusio acetabuli), and a large subcutaneous nodule.

As mentioned above, Nava[5] reported the only other case in which a patient with rheumatoid arthritis later developed a stroke. His observation of an acute exacerbatian of the arthritis on the hemiplegic side does not fit the hypothesis of "protective effect" and is as yet without explanation.

Of great interest was the development of subcutaneous nodules in only the nonparalyzed limbs in two of the four cases of Thompson and Bywaters[2] and in the case of Bland and Eddy.[4] Noteworthy, too, was the almost complete disappearance of the subcutaneous nodule from the paretic side in our case.

Some interesting experimental studies of adjuvant-induced polyarthritis in rats have shown that the trauma of joint motion may play a role in localization of arthritis, while immobilization may decrease the amount of involvement of the joint.[11,12] Schumacher[13] recently described leakage of carbon particles from synovial blood vessels after joint motion of the synovium of monkeys as seen by electron microscopy.

The mechanism by which hemiplegia protects joints from developing arthritis has not been elucidated. However, the hypothesis that failure of arthritis to develop because of disuse of the hemiplegic limb has been suggested.[2,6,7] Immobilization has also been implicated as a beneficial form of therapy in rheumatoid arthritis.[14]

Now that articular disease similar to that seen in humans can be induced in some animals and new surgical procedures have been found to interrupt nerve pathways, it is intriguing to speculate that induced polyarthritis combined with neurosurgical operations such as cryothalamectomy may provide new models to study pathogenetic mechanisms in arthritis.


### Summary

The coexistence of rheumatoid arthritis and hemiplegia has been described infrequently. In previously reported cases, arthritis developing subsequent to hemiplegia was largely limited to the nonparalyzed extremities.

The present report is the first in the English language literature which describes a patient with long standing rheumatoid arthritis who subsequently had a stroke; she had amelioration of arthritis on the paretic side with progression of arthritis on the nonparetic side. A possible explanation for the improvement is the relative immobilization and disuse of the paretic side.


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181

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**Adverse Reactions:** *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.
**Usual Adult Dosage:** 1200 to 1600 mg daily, in three or four divided doses; doses above 2400 mg daily not recommended.
**Overdosage:** Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

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# The Rising Cost of Health Care and Underutilization of Visiting Nurse Services in Baltimore

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**Poor utilization of visiting nurse services in Baltimore is examined in the context of rising hospital costs. Home Health Care Programs and patterns of use of visiting nurse association services by independent physicians and by hospitals are explored. Reasons for and ways to secure better utilization of such services are discussed.**

## Economic Background

Today, virtually everyone in America decries the increasing costs of medical services. Since 1935, the amount spent on health in the United States has increased by more than 30 times.[1] Although part of this change represents more services to more people, much of it represents increased price per service.

During 1966-67, medical care expenditures increased by almost 13%, while our gross national product increased by less than half this amount.[2] With present trends, we can expect total health expenditures for the country to be between $110 and $120 billion as early as 1975. The major component of increased total health expenditure is hospital costs (42%).

The reasons for the rise in costs of hospital care give no encouragement that we can expect reversal or even slowing of this trend in the near future. Two important factors in the increase in hospital costs are the steady rise in earnings of hospital employees and the fall in their productivity. A third, but less significant, factor is the general increase in cost for hospital meals, drugs, maintenance, depreciation, replacement, and other items.

Hospital employees have been underpaid in relation to other workers. Almost one third of all hospital employees earned considerably less than $1.25 an hour in 1963.[3] Since that time, new minimum wage laws and the trend toward unionization have resulted in a marked increase in hospital employees' wages; it is unlikely that this trend will be reversed in the near future.

The number of patients cared for per hospital

employee per hospital day — in other words, the productivity of hospital manpower — has been falling. While most industries have been increasing productivity by substituting automated equipment, hospitals as employers have had increased demands for skilled, semiskilled, and unskilled workers.

It is not enough to view with alarm the rising costs of medical care. Corrective measures must be considered. What costs might be easiest to reduce? Physician services and hospital care are the largest components of medical care expenditures. In the past ten years, hospital costs have more than doubled, and now take up a greater proportion of the total health expenditure.[4] Therefore, we should examine the possibilities for reducing hospital care or substituting other care for inhospital services. The second alternative is the focus of this article.

The former Secretary of HEW, John Gardner, advocated broadening private and public health insurance plans to include alternative types of medical care. Home health care services were specifically mentioned as one method to slow the rise in health costs and to encourage greater efficiency in the delivery of medical care.[5]

In Baltimore, the cost per visit for the Instructive Visiting Nurse Association (IVNA) was $10 in 1970 while the average hospital day cost was $80 (projected for 1971).[6] We cannot compare these two costs directly, as they do not represent the same level of service. Our major contention is, however, that major savings can be realized if patients can be discharged earlier through the utilization of IVNA services. Some externalities are not taken into account by this comparison: the costs of food, heating, and shelter provided at home rather than in the hospital, and the costs of time of family members who care for the patient at home. These costs are small, however, in relation to the costs of care within a modern general hospital — certainly less than one fifth of total hospital costs.

We emphasize that economic reasoning should not be the sole deciding factor for increased use of home health care. We believe that most patients are far happier in their own homes than in the hospital, whenever it is medically appropriate for them to be discharged to a home health care service such as that provided by the IVNA. The experience of one program in Baltimore has been that ". . . most people we can take care of at home are much more appreciative than if we had put them in a hospital or a nursing home."[7]

## Development of Home Health Care Programs

Obviously, unorganized home health care antedates hospital care. Organized district nursing and home visiting, however, dates back to William Rathbone's work in Liverpool in 1859. District nursing was introduced in America in 1877.[8] The New York City Mission employed trained nurses to give care to the sick poor in their homes. Other communities gradually adopted the idea. The first nursing associations organized directly for this purpose started in Buffalo (1885) and in Boston and Philadelphia (1886). Eventually, all of these agencies were called Instructive Visiting Nurse Associations (IVNA) indicating that teaching was a recognized objective for the district nurse, along with the care of the sick in their homes. The agencies were all voluntary, supported primarily by contributions and secondarily by small service charges.

Comprehensive Home Health Care gained a major impetus with the inception of the Montefiore Hospital Home Care program in 1947 in New York City. This extramural project was aimed at those patients who needed certain hospital services and facilities over a variable period of time but did not need hospitalization *per se*.[9] Services available were physician visits, medication, physical therapy, social service, housekeeping service, occupational therapy, transportation, and nursing.[10] The latter was provided by the Visiting Nurse Service of New York and included general bedside care, specialized procedures, instruction of appropriate family members in such activities, and a variety of other tasks.[11]

The Montefiore idea was adopted and widely applied by the New York City Department of Hospitals during 1948-1950 with the establishment of a municipal Home Care Service which by 1964 had reached more than 2,000 clients. In general, the nursing care was again provided by the Visiting Nurse Service.[12] This program had potential for greater expansion but was limited by constraints of budget and staffing.[13]

The organized home care concept spread to southern New York State where the home care program covered over 5,000 patients per year.[14] The program grew less rapidly in the voluntary hospitals than in the local government hospitals.

In Rochester, New York, an exemplary home health care program was started in 1960 by the Monroe County Health Department and the Visiting Nurse Association. The program has an average daily census of 200, with over 100 dis-

charges per month.[15] Representatives of the Baltimore City Medical Society and Maryland Blue Cross visited the Rochester Program in June 1971 to gather information for planning a similar system in Baltimore.

These examples show that home health care programs have been established and supported by a variety of different agencies and institutions including public and private hospitals, health departments, and the IVNA itself. In addition to the examples cited, well over 200 home health care programs are now functioning in the United States. How does the Baltimore metropolitan area measure up in the development of needed home health programs?

### Home Health Care Programs in Baltimore and Maryland

The first hospital-based home health care program in Maryland was proposed by Dr. Frank Furstenberg in 1957. After some difficulty in finding support for the plan, it was started at Sinai Hospital in 1961, utilizing the Instructive Visiting Nurse Association to provide the home nursing services. Over the past ten years, only one other hospital in the metropolitan Baltimore area has established an official home care program. The idea has not spread widely in the rest of Maryland. Only two additional hospitals in the state are listed with the Hospital Council as having home care programs.

What are the reasons for the slow development of hospital-based home care programs? One reason might be the lack of major financial incentive to the hospital. Patients who could be cared for at home are the least costly patients for hospitals, and hospitals are usually reimbursed at the same rate as that for critically ill patients whose care is more expensive. Possibly by keeping such patients in the hospital, administrators are able to keep a lower average daily cost for hospital inpatients.

Moreover, for the attending physician interested in the patient's financial problems, the incentive to send the patient home is less than the incentive to let him stay in the hospital. At present, Blue Cross, Medicare, and other third-party payers have severely restricted Home Health Care coverage. When the health system is fragmented sharply to inpatient and outpatient care by methods of reimbursement, the hospital segment may optimize its own efficiency at the cost of decreased efficiency and increased costs for the total health system, and thus for the community.

In addition to the hospital-based system, the Baltimore City Health Department provides a form of home health care through its special home services program with the bureau of public health nursing. The former provides a linkage service between elderly, chronically ill, low-income persons and social agencies, hospitals, and other facilities which they may need. Public health nurses work closely with the Instructive Visiting Nurse Association and refer patients who need bedside or other nursing care. Aside from this, the main connection between the IVNA and the city health department is that the latter provides partial support of the IVNA program for indigent patients and some home health aide services. (The pattern is quite different in most counties of Maryland as the county health departments have their own programs of home health services.) In Baltimore, the IVNA is the action agency for most home health care services for the Baltimore City Health Department.

The IVNA plays a crucial role in any improvement of utilization of home health care in Baltimore, for all of these programs employ the IVNA as the main agency to deliver home health care services. This leads us to the activities of the IVNA in metropolitan Baltimore.

### IVNA in Metropolitan Baltimore: Background

The Instructive Visiting Nurse Association in Baltimore was organized on November 25, 1895, with the object of giving bedside care at home to the sick poor who could not or would not be sent to a hospital; and teaching proper care of the sick, personal hygiene and sanitation, and the prevention of disease. Within the provisions of a constitution and by-laws, a fee for service was established which instructed the nurses "to collect at least ten cents for each professional visit except where, in their judgment, the families are unable to make any payment." During the year, about $300 had been raised and in January 1896 the organization opened an office in a shop on South Charles Street.

In the early days of the Association, all types of cases were cared for, as the Instructive Visiting Nurse was the only organized group of nurses giving this type of care; it was the first organization in the State of Maryland to attempt Public Health Nursing and to demonstrate the value of the work of the Visiting Nurse. It in no way duplicated or conflicted with any existing agencies for relief of sickness. Surprisingly, the greatest difficulty at the beginning was not in securing patients and knowing what work to do, but in overcoming the unfriendly attitude of doctors. Many doctors felt that the nurses would interfere

with their practice. But when by word and action it was explained that nurses would undertake work only under the direction of a doctor, the attitude of the profession changed and a friendly, cooperative relationship was assured.

By the 50th anniversary, at the end of World War II, service to acutely ill persons had decreased and responsibility for the prevention and care of communicable disease had been gradually assumed by the Baltimore City Health Department. As a result, services rendered by the Association today are predominantly those associated with chronic illness.

Financial support of the Association is provided by the Community Chest, fees for service paid by the patient and/or various governmental agencies, and a contractual arrangement with the Baltimore City Health Department.

### IVNA in Metropolitan Baltimore: Current Activities and Patterns of Utilization

Presently, the Baltimore IVNA employs 23 registered nurses, 14 licensed practical nurses, 11 home health aides, and two physical therapists (Table 1). One or more staff members is available every day, including weekends and holidays. Positions for other professionals to make home visits, including an occupational therapist, speech therapist, and mental health consultant, are being staffed or are approved.

During 1970, the IVNA staff made over 48,000 visits to approximately 6,400 individuals who required nursing care or physical therapy at home in Baltimore City and the metropolitan portion of Baltimore County. As seen in Table 2, over the past ten years there has been a decline in patients, in visits, and in staff productivity. The number of visits per patient has remained relatively constant at about 7.5. Staff productivity, however, appears to have declined from approximately 6.7 to 3.7 visits per working day. Major types of service rendered included bedside care and treatment (27%), health counseling (23%), hypodermic injections and other treatment (31%), physical therapy, massage, and exercise (9%), and instruction in care or treatment (4%). Patients were absent in 6% of the visits. The major trend over the past decade is a decrease in health counseling and consequent increase in direct service.

**Table 1: IVNA Personnel, Baltimore City, 1961 and 1970**

| | 1961 | 1970 |
|---|---|---|
| Registered Nurses | 28 | 23 |
| Licensed Practical Nurses | 17 | 14 |
| Home Health Aides | .... | 11 |
| Physical Therapists | .... | 2 |
| Total | 45 | 50 |

**Table 2: Utilization of IVNA Services**

| | 1961 | 1970 |
|---|---|---|
| Total number of patients seen | 8,104 | 6,404 |
| Total number of visits made | 60,973 | 48,147 |
| Visits per staff member | 1,742 | 963 |

More than one third of the patients seen were 65 years of age and over. The percentage of patients over 65 almost doubled between 1960 and 1970. Approximately one half were black; over two thirds were female. Of the total number of patients seen, 58% were chronically ill and required 82% of all visits made. Patients with heart disease (including hypertension), cancer, stroke, and diabetes accounted for nearly one half of the visits. The remaining patients were either acutely ill (4%) or required assistance in matters pertaining to maternal and child health (36%).

Over one fourth of the visits in 1970 were made without charge to the recipient. Payments under Title 18 (Medicare) covered the costs of almost one third of all visits, and Title 19 (Medicaid) covered another one fourth. The remaining costs were reimbursed through various other programs and contracts. As noted above, the average cost per visit was about $10; the average cost per patient was $75. The changes in financial support over the past decade are striking (Table 3).

The largest number of Association referrals was received from hospitals, in particular University, Union Memorial, Johns Hopkins, and Sinai. As can be seen in Table 4, however, referral rates per 1,000 discharges differ markedly among these four hospitals. During 1970, more than two thirds of all patients seen were posthospital discharges. Family and friends referred an additional 14%, while physicians outside of hospitals referred 12%. Baltimore City Health Department referrals have decreased by 50% since 1965. In 1970 only 46 patients were referred by the city health department — a surprisingly small number considering the health department's responsibilities. Referrals by families and friends and private doctors have increased slightly in the past five years, while hospital referrals have decreased. The reasons for the higher rates at some hospitals and evalu-

| Table 3: Sources of Income | 1961 % | 1970 % |
|---|---|---|
| Medicare | .... | 29 |
| Medicaid | .... | 20 |
| Community Chest | 77 | 22 |
| Patient | 15 | 7 |
| Contracts | 3 | 5 |
| Grants | 1 | 14 |
| Endowment | 4 | 3 |

| Table 4: Referral Rates Per 1000 Discharges For Four Metropolitan Baltimore Hospitals | 1961 | 1965 | 1970 |
|---|---|---|---|
| University | 202.9 | 141.0 | 100.3 |
| Union Memorial | 66.6 | 71.1 | 94.4 |
| Johns Hopkins | 43.9 | 50.9 | 19.6 |
| Sinai | 5.7 | 13.2 | 15.3 |

ation of the effects of use of IVNA services on the length of stay are subjects for future fruitful inquiry.

### Conclusions and Recommendations

Utilization of IVNA services in metropolitan Baltimore has actually decreased over the past years. With the appointment of a new director, interest in improving utilization and recruiting and training new staff to fill the extensive unmet home health care needs of the area has been renewed.

Improved utilization of home health care services will be important in: 1) reducing the overall expense of the health care system; 2) providing greater patient satisfaction; and 3) easing the pressure for hospital beds, and possibly even precluding the necessity for additional hospital construction.

How can this increased utilization of home health care services be accomplished?

1. Since all patients cared for by the Visiting Nurse Service must be under the supervision of a physician, the primary responsibility for increasing utilization rests with metropolitan Baltimore's physicians, as individual practitioners and as hospital staff members.

2. Future mailings to members of the Baltimore City Medical Society will contain reminders and sources of information on home health care services. Information on the existing sources of financing and services for home health care patients hopefully will be disseminated to all physicians in the metropolitan area.

3. Physicians should encourage establishment of home care coordinators or Home Care Programs in hospitals.

4. The Baltimore City Health Department should evaluate its referral rates to the IVNA.

5. One of the main purposes of this article is to solicit ideas and suggestions from the readers of the *Maryland State Medical Journal* for ways of making practitioners more aware of the services, ways to encourage development of hospital-based home care programs, and ways to make these programs effective. Any suggestions or problems relating to utilization of home health care would be most appreciated by the authors. Serious attempts will be made to implement your ideas for improving home health care utilization.

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ART AND HOBBY EXHIBIT

# ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

## MAY 3, 4, 5, 1972

## BALTIMORE CIVIC CENTER

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### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: **Chairman, Art and Hobby Exhibit**
**Medical and Chirurgical Faculty**
**1211 Cathedral Street, Baltimore, Maryland 21201**

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height .....

3. Electrical or other requirements: .....

.....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

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An Art and Hobby Exhibit will be held during the 174th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted. However, it is strongly urged that APPLICATIONS be received in the Faculty office BY APRIL 15.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, May 2, 1972. They must be removed on Saturday, May 6, before 1:00 PM. The Faculty cannot carry insurance on exhibits. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies should cover the exhibit. Entries should be submitted as early as possible.



HOBBY DISPLAY—Great interest was shown in the Art and Hobby Exhibit at the 1971 Annual Meeting of the Medical and Chirurgical Faculty.

# Opportunities and Procedures for the Early Diagnosis of Carcinoma of the Cervix

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*In providing the Hundley Memorial Lecture in Gynecology for the 171st Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, this panel of three doctors discussed the practical aspects of opportunities and procedures available for the early diagnosis of cancer of the cervix. Their discussions centered on such questions as the desirable frequency of obtaining smears, procedures to follow and procedures not to follow when smears are other than negative, the role of colposcopy, the role of chromosome determination, the value of community screening, and other related problems. Their presentation has been adapted for JOURNAL coverage at this time.*

*Dr. Jones*: Few of us remember Dr. Hundley, Sr., but those who remember his son, Dr. Jack Hundley, Jr., will understand what I mean when I say that it is indeed a privilege to participate in a program which is dedicated to the memory of Dr. Hundley, Sr., and, since 1967, to the memory of Dr. Hundley, Jr.

It's particularly fitting that the Hundley Memorial Lecture should be concerned with the early diagnosis of cancer, and particularly cancer of the cervix. Why? Because I think Dr. Hundley, Jr., did more in his time than any other single person to bring about the necessity of having this session on the early diagnosis of cancer. Dr. Hundley, Jr., was one of the founders of the Maryland Division of the American Cancer Society, and as such was responsible for education and other things which made this program necessary.

The reason this program is necessary is that the diagnosis of early cancer of the cervix has changed very considerably in a short period of time. There is no problem in diagnosing an invasive cancer of the cervix. Anybody can look at the cervix and suspect a serious problem exists and, with a biopsy forceps, make the diagnosis. When intra-epithelial carcinoma was first described — within the memory of most of us here — it was usually relatively easy to diagnose. In fact it was usually diagnosed with a biopsy taken on routine indications, or with very slight abnormalities in the appearance of the cervix.

However, the use of exfoliative cytology has changed all that. The lesion of intra-epithelial carcinoma is getting smaller and smaller, and it is more and more difficult to find. From a practical point of view, the question before us is what to do when a routinely obtained smear is other than negative. And your cytopathologist may report this as suspicious (Class 3, 4, or 5), or whatever terminology he uses; and it is then up to the clinician to decide how to treat the patient.

If you look at the cervix under this circumstance, you usually cannot see a target lesion. Do you biopsy it, or what procedure should you carry out?

What do you do when given an individual who has a smear obtained by whatever method, but nevertheless routinely where there are no symptoms in relation to the pelvis, and your cytopathologist reports that this smear is other than normal?

At this point I would like to call upon Dr. Frost as a pathologist and ask him what additional material he would like to obtain from the patient under the circumstances described.

*Dr. Frost*: I would think that the first thing one should think of — and this certainly depends upon the severity of the diagnosis — could be a marked inflammation or quite a bit of repair, a lot of obscuring — possibly even an inadequate sample — but some atrophy that the pathologist wants to look for in more detail.

From these relatively minor things, we proceed all the way through the gamut to out-and-out cancer. Dr. Jones included positive, which would be out-and-out cancer. The one stipulation he has given us is that there is no lesion—no really obvious lesion. If there is any lesion visible, it definitely should be biopsied.

From the cytology point of view, what could be wanted would be a repeat smear immediately at the next examination; if a lesion is present, then biopsy. Keeping in mind the fact that this is a problem patient, one should look at the report very, very carefully to see if he can determine the problem. In other words, if there is heavy inflammation, he should do what he can to attempt to reduce the inflammation. If the man is very concerned and he recognizes a severe dysplasia, he should go about his business in trying to do what the pathologist's indications would also indicate to him.

This is one of the most important times for the clinician to get on the telephone and talk with the pathologist and really be able to talk and ask the pathologist what was found rather than just a 2, 3, 4, or 5 which are somewhat meaningless. Most pathologists prefer to talk to the clinician and tell him just what was found.

The repeat cell sample must definitely be entirely adequate. A repeat cell sample, in order to be adequate, not only must look adequate, as though it has a lot of material on the slide, but it should also come from the right place. One realizes that the lesions one has in the cervix in these very early neoplasias are not a single lesion.

(*At this point, Dr. Frost showed and described a series of slides. The first pictured a uterus which had been removed.*)

These early lesions are not all uniform. You can see a leukoplakia in the lower portion of the endocervical canal. The white area is the lesion. As you know, leukoplakia is a clinical designation meaning white patch. In this case, this really designates the area of disease; but the disease actually goes from just a very minor atypia all the way through to cancer.

Marsh went through hundreds of cases of cancer of the cervix looking for the very early lesions and pulled out 44 consecutive ones. These cancers were so early that they involved either the endocervix or the exocervix but not both. As you will note in this slide, this is such an early lesion that it differs from practically all of the cancers we have heard about in medical school. In reviewing these 44 cases, Marsh found that the endocervix had 42 (95%) of those cancers, and that many of these had lesions on the exocervix which were severe dysplasia, were moderate dysplasia, or were normal.

I'd like to make a point here that when one uses the terms cervical sample, cervical scraping, cervical swab, pap smear, etc, they really mean nothing. There are some who refer to cervical as being the exocervical only, and we can see this would mean missing the very early lesions.

The vaginal pool should not be forgotten. Even though it is very low in picking up early lesions of the cervix, it is very helpful in picking up some that this cervical scraping will miss. It's also helpful in picking up the endometrial lesions, lesions of the ovary, and in detecting abnormal hormonal patterns.

The lesion on the cervix depicted on this slide was of an infertility patient who, cytologically, had cancer. In lesions such as this, the biopsies reveal in situ but one wants to be sure the patient does not have a more severe lesion and does not have invasion in addition to in situ. Or, if biopsies such as this do reveal a severe dysplasia, one wants to be sure the patient doesn't have an in situ or an invasive somewhere else. In order to cover the waterfront, biopsies have to be a conization because cell samples cannot.

If there's inflammation, many times this will be very disconcerting to the pathologist; this may be the reason that this patient was not negative and that the patient bothered and worried him.

If one is able to find a specific inflammatory agent (as shown in the slide), many times one will see trichomonas. This happens to be tricho-

monas in the epithelium of a metaplasia down in a gland. This shows the types of cells and the marked inflammation obscuring degenerated, hemorrhagic necrotic background which can obscure cancer if cancer is present. Cancer and trichomonas are frequently present. Very frequently cancer and monilia are present and herpes frequently is present. If anything specific is noted, one should do all he can to overcome the inflammation.

At the time the patient comes in, repeat cell samples should be taken. One should try to get the inflammation out of the way and have the patient come back a week or two later and then repeat cell samples during this time.

And, finally, if a patient has a very atropic type of vagina and has atropic vaginitis, it can be gotten rid of very easily with a little bit of estrogen to give the patient a pattern of the vaginal smear that any woman of child-bearing age would be proud of. If the patient had cancer, it would be very obvious. If the patient did not have cancer, it would also be very obvious.

Basically, I think one should be concerned that he obtains adequate cell samples; one should be concerned that he obtains adequate tissue samples if they are indicated; one should be concerned that he does a very, very careful inspection of the cervix, and the adnexa; and a very careful history of the patient should be done to see if there is anything he can pull from the patient that might possibly help him understand problems that the pathologist is having. The liaison with the pathologist is of extreme importance.

*Dr. Jones*: What I got from Dr. Frost's presentation was that he wants lots of material from this patient who has the positive or doubtful smear. I think I'm going to come back and ask Dr. Frost a little more specifically about the order in which he wants them because I'm a little uncertain from what he said as to whether we pull all the triggers the next time we see the patient or whether various materials are obtained serially. Before doing that, I would like to ask Dr. Davis to address himself to this question from the point of view of the clinician.

Remember the situation. We have this patient with no visible lesion in the cervix but with a doubtful or positive smear. Now, Hugh, where do we go from there?

*Dr. Davis*: Of course this is the most troublesome group of patients to deal with since they represent a group that, on further investigation, runs the gamut when you finally track them down, as Dr. Frost has indicated, all the way from frank invasive cancer that you miss visibly, but may be lurking in the canal, for example, in a postmenopausal woman with a small closed cervix. It may range, in fact, all the way from that to a very mild regenerative process that is producing a very small number of atypical cells.

I'm on the receiving end of many of the reports that issue from Dr. Frost. The first point which is very helpful is the point that he has stressed of a meaningful report if the cytologist is able to make such an interpretation if the specimen is adequate. There are really two kinds of specimens which may be reported back as suspicious.

The first kind is that in which there is not really good material because of degeneration or inflammation, or inadequate collection in which the cytologist needs help in additional material before he can make a more precise pronouncement. The second is a group in which there is reasonably adequate material but the patient, because of atypicalities, requires investigation.

The first group is relatively straightforward to deal with. The gentleman has to indicate, besides the presence of the atypicality, that the specimen indeed is not really satisfactory or adequate.

At the clinical end, I know that it is a little aggravating to receive a report of biopsy or smear not being optimal or adequate. This is not a reflection on the efforts of the clinician but, I think, a reflection of the honesty of the individual in the laboratory who receives the specimen.

If he isn't giving you some unsatisfactory reports from time to time, I think that possibly he is not doing the job for you that he should be doing. That job is to tell you when you are not giving him the material he needs to tell you that the patient is in a suspect or a negative category.

I believe the first step is the procurement of additional material. There's a little confusion with regard to the taking of material and how it should be handled. If we're talking about squamous lesions, one thinks of the early lesion as being the very, very early squamous lesions of the cervix, whether classified as dysplasia or as carcinoma in situ.

These lesions invariably have at least one foot on the squamal columnar juncture, the juncture between the gland-bearing area and the normal squamous epithelium; this is the area of the so-called erosion or eversion. At that junctional area, we see the first clinical changes and we pick up the first changes pathologically. The problem as to whether the early lesion is endocervical or exocervical is really a question of

whether the last gland is endoclinical or exo. Clinically, some women have a considerable eversion in the gland-bearing area; therefore, the juncture is well out on the portio. This is true of some 87% of premenopausal women.

Whereas in postmenopausal women the cervix tends to be smaller, the os tends to be more closed and the squamal-columnar juncture tends to a greater and greater extent up into the canal. So I think the first point has to do with the indication that the cytologist can give you.

If you have a report of a mild dysplasia or a mild atypia of squamous type, he can tell you the cellular type. In a patient that needs to be investigated, this is an indication that at this time one should obsessively go around, if you didn't obsessively take the smear from that exact juncture and go around circumferentially, very carefully getting into all the little clefts and knots and irregularities that may exist. I don't mean traumatically, but systematically. If necessary go around several times and if the juncture is in the canal then that's where the smear needs to come from if it's a squamous type of lesion and of the cervix that is suspected.

If one suspects an adeno type of lesion, which the report can indicate, that is what we are talking about moreso than simply classes, but a descriptive indication of the cell abnormality one is looking for. Then a lesion at a higher level may indeed exist, and one perhaps needs several samples from several different areas in order to evaluate this.

I'd like to put in a good word for the biopsy in this regard, even in the absence of a gross lesion, if one has repeated cytology consistent with the presence of an early neoplasm of the cervix. That is to say that if one has repeated the cytology and is satisfied that there is good solid evidence of an actual neoplasm, the taking of a Schiller test, the localization of a squamal columnar juncture, and, if necessary, obtaining blind biopsies from the canal are still very good ways of picking up invasive carcinomas at a relatively early stage of evolution. And if you can detect an invasive carcinoma by biopsy without regard or resort to conization, you are a step ahead as far as planning the treatment of this patient is concerned.

You have foreshortened the procedure as far as diagnosis is concerned, and you have made radiotherapy much less complicated. In the last five years' experience at our own hospital, there have been only two invasive squamous carcinomas, to my knowledge, that have been diagnosed by conization that had not previously been diagnosed by biopsy prior to therapy.

And by that I don't mean to say that, if the biopsies are negative, you ignore them but simply proceed on the basis of the persistent atypical cytology. Most of the invasive carcinomas can be picked up and identified by an aggressive clinician who is focused on the squamal-columnar juncture and on the cell type that he is looking for.

*Dr. Jones:* Dr. Davis also wants more material. For what it's worth, in order to bring to a focus our search for the lesion which is responsible for this other than negative smear, it might be of some interest to go through the process which we use at our own institution by showing you how we handle two or three patients.

We have a colposcopic clinic which is run by Dr. Davis. All patients who have other than negative smears are referred to this clinic. The purpose is to enable the clinician at that point to better localize the area in the cervix from which he wishes to get additional material. As I explained, with the increased sensitivity and use of exfoliative cytology, smaller and smaller lesions are being revealed, and the blind biopsy may miss them.

When patients go to the colposcopic clinic, they have additional directed smears and directed biopsies with a colposcope; then they have a special method of diagnosis by determining the chromosomes of the lesion which is an experimental method. Then they have an ordinary histopathological section taken from a section adjacent to that which was used for the chromosome determination.

We'll run through rather rapidly a case of out-and-out carcinoma and then show you a problem case. The slide simply shows this particular patient who was seen on two occasions; the cytopathology was positive on both occasions. The colposcopy was essentially positive on both occasions. The biopsy the first time showed moderate atypia, but the biopsy the second time was read as early invasive carcinoma.

This is an example of chromosomes taken from this particular patient. As you know, 46 chromosomes are the normal human number, but there are 81 chromosomes in the cells of this particular carcinoma, and this has been a constant finding. Aneuploidy of the chromosomes is indeed synonymous with a diagnosis of cancer; it's another method of diagnosis of cancer of the cervix.

In this second case, we begin to see a divergence in the diagnostic criteria with which the diagnosis of cancer is made. The patient was seen in December and again in January with inconclusive cytopathology. Dr. Frost gives us

three classifications: negative, inconclusive, or positive. This is the type of patient that requires further investigation.

This in colposcopic language is a very suspicious lesion. Histopathology in December was marked atypia, not carcinoma, and, even when she had a hysterectomy, there was marked atypia. It was impossible histopathologically to make a diagnosis of cancer here.

I'll simply describe the last patient. She had a suspicious exfoliative smear, but only atypia as far as histopathology was concerned, with completely normal chromosomes indicating that this was not a malignant lesion but an inflammatory atypia. I think the thrust of what I'm trying to say is that, in a patient who has other than a negative smear, one cannot immediately jump to treatment of that patient on that basis. In these days of very early lesions, one must determine whether there is indeed a needle in the haystack by sophisticated methods of diagnosis. In the absence of the availability of these, further cytologic examination should be made. I might say it is important to avoid cauterization of the cervix which, in my judgment, can conceal for a prolonged period of time a smoldering lesion which might blossom later.

In the short time remaining, I would ask Dr. Davis to comment about the effect on deaths from cancer of screening a population that is willing to be screened.

*Dr. Davis*: We would like to leave on a more positive note. We've been talking about the problems created by cytology. As some of you know, a program started over five years ago in Washington County, Maryland under the auspices of the Maryland Division of the Cancer Society, and with the cooperation and support of the Washington County Medical Society.

The experiment tried to carry through to the point of eradication of invasive cervical carcinoma by identifying early lesions through cytology taken in physicians' offices as well as cytology taken by an intensive screening program with irrigation smears in the 30-to-45 age group, a high-risk age group for these very early lesions prior to invasion.

Both screened and unscreened women were included in the raw figures. The program was initiated in 1962. By 1965 a very dramatic drop in the number of invasive cancers began to occur and has continued to occur. At the same time, commencing in 1963, a very dramatic rise in the diagnosis of these early lesions occurred.

We broke the cases down into groups in which invasive cancers were appearing in the screened and nonscreened population in the next five years, ie, women who had been cytologically picked up, referred to their doctors, investigated according to the principles that we're discussing here, and, if the lesion was confirmed by subsequent smears, had appropriate treatment, and then the nonscreened.

The screened group of women was essentially clean in a calculated statistical group of 10,000 women. In the next five years we got three cancers statistically, in the women who had not been screened, and had therefore not participated and had not had the benefit of having their severe dysplasis or their carcinoma in situ picked up. There was a rate of 80 per 10,000 women in five years. I don't think there's any question whatsoever from this kind of experiment that the identification, follow-up, and appropriate management of the patients with these very early lesions was resultful.

Whether they maintain moderate or severe dysplasias, or whether they be carcinoma in situ, it is possible to effectively prevent 90% or more of invasive carcinoma.

*Dr. Jones*: We have not had an opportunity to invite audience participation, and I see that our time is up. I apologize if some of you have comments or questions. We will be available and happy to discuss any of these matters with you privately.

In conclusion, I thank Dr. Frost and regret that I'm not able to come back to him and be more specific about the material he wanted. I also thank Dr. Davis for his participation in the program.

## Letters to the Editor

I have been informed by Hopkins' friends that my article, "Changing Attitudes and Practices Concerning Abortion: A Sociomedical Revolution," printed in THE JOURNAL, December 1971, may confuse the casual reader. On Page 63, I wrote, "The Woman's Medical Service of which Dr. Allan Barnes is now Chairman does 100 abortions a day." This refers to Dr. Barnes' current activities in New York and does not refer to his years of stewardship of the Woman's Clinic at The Johns Hopkins.

As a former member of the Department of Obstetrics at The Johns Hopkins, I am anxious that no one misread the paragraph I alluded to.

ALAN F. GUTTMACHER, MD
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Parenthood-World Population
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New York, N. Y. 10019

# BLUE SHIELD AND HEALTH CARE

**NED F. PARISH**
**President, NABSP**
**(National Association of Blue Shield Plans)**

*This speech was given to the Blue Shield Annual Program Conference in Washington, D. C., October 8, 1971. It is reprinted here as a service to Med-Chi readers.*

I have noticed, and so probably have you, that people who have been with Blue Shield for a long time don't refer to the Blue Shield business. They refer to it as a movement. It is quite possible to expand this into a five-act opera, which I won't. But the basic point is that this movement — or business, whichever it is — is here not for the purpose of making money, but to render service. Our service has been the financing of health care. We have built it on two fundamental premises. First, the actuarial premise, that by pooling resources we can help the fellow who gets sick to meet those expenses without financial devastation. Second, the premise that as sophisticated purchasers of service, we are in better position to buy care than the individual himself. Both of these are perfectly valid.

But some of you will remember the Kepner-Tregoe premise, too. This holds that when actual results deviate from anticipated results, you've got a problem. We anticipated that if the bulk of the population got coverage, they would get more and better care, with relatively little economic hardship, and that they and the providers would be happy. Actually, the bulk of the population did get coverage, they did get more and better care, they did suffer relatively less economic hardship, and yet neither they nor the providers seem particularly happy. Which certainly creates a problem for us.

But the public has a problem too. It accepted the premise that if it gave us funding and growth, its logistic problems would be pretty well taken care of. The general view seems to be that these results have deviated somewhat from expectations.

Looking back, we could describe the evolution of the problem this way. When Blue Shield began, medical care in America had a relatively narrow economic base. Fewer people saw physicians, and they saw them less frequently. The majority of physicians had little training beyond the internship, in part because so many patients were unable to provide an adequate economic base for the higher quality of care made possible by specialization.

We and, later, others built a much broader economic base. We made it possible for many more people to be exposed to medical care, to learn its value, and to want more and better care. And as a broad general economic base makes it possible for people to pull out of food production to make and market automobiles, the broader economic base in health care made it possible for people to pull out of primary patient care to develop more effective specialty care, so that medicine itself became a more valuable commodity, which more people wanted and needed. The social pressure of this awakened desire, expanding much more rapidly than the supply of health resources, has created, at least in many minds, a health care crisis.

This is frequently attributed to disorganization and lack of coordination in the health care system. The health care system is, in fact, no more disorganized and uncoordinated than the

demands that are made upon it. It works remarkably well to do what it was designated to do: bring the highest possible level of training to bear upon the specific problems of the individual patient who uses the system, giving lesser priority to economy or to service to those who, for whatever reason, do not present themselves for care. This orientation was perfectly acceptable to an earlier society. Today it is not. This seems to me to emphasize the urgent need for the establishment of realistic national health objectives encompassing, but not limited to, the health care system.

NABSP has recommended both to the Administration and to Congress that a national health policy body be established, whose function it would be to identify what steps can be taken to improve the national health, and at what price. We have had some criticism of this position on the grounds that it is vague and philosophic.

But the critics missed the point, which is that health is a very complex equation involving hard choices between competing demands. At the level of the national government, these demands are not only between health and other things — defense, education, agriculture — but they are present even within the health field. Sanitation, diet, health education, health manpower, and other factors impact on health, as much and possibly more in the aggregate than as personal health services themselves.

We do not believe that any one organization can specify at present what those priorities should be, nor that they should be cast in the bronze of permanent legislation. What we need is a mechanism to make decisions, set priorities, and give the health care system some organized demand to which it can respond. At the same time, the government can achieve a means of using its funding and legislative powers intelligently in support of the total national health, which is quite different from the more narrow field of personal health services. The health of a nation is the product of a complex set of educational, economic, sociologic, geographic, and ecologic factors, of which health care is only one. Concentrating on any one factor at the expense of all others is unlikely to produce the best result. This has to be recognized in order to establish priorities for financing in these multiple areas.

It is also important in devising standards of measurement. The American system is castigated as disorganized and ineffective because of its relative position in world infant mortality figures, to cite one recurrent example. Yet American figures are better than those of the U.S.S.R., which may have the world's most organized health system. And they are better than those of Israel, which has the world's most favorable physician-patient ratio. Rather clearly, neither organization nor physician supply, nor simple entitlement to care is, in itself, the answer to infant mortality.

It seems to me that a rational approach to the real problems that exist in the health system has to take several assumptions into consideration.

First, the supply of health personnel can't be expanded rapidly and effectively. Even if the gross numbers can be, particularly in the paramedical areas, the disciplines have got to learn to work together. There have been studies which show a considerable difference between what physicians think medex personnel should be able to do, and what they themselves would permit them to do in practice. This disparity can only be worked out through confidence, which is a product of experience, which is, in turn, a product of time. Time, of course, can be reduced, and we should do what we can to reduce it.

Second, it is not at all certain that the public can or will provide enough money to provide unlimited health care. Allowing demand to seek its own level in the absence of the braking effects of cost and availability would be an enormously expensive proposition. Dr. Sidney Garfield of Kaiser-Permanente was being anything but facetious when he pointed out that one of the major benefits of automated multiphasic testing is its help in meeting the increased demand when patients do not pay for individual services.

The third point is that most health care is and is going to remain episodic and crisis oriented, given the present state of clinical science. Keeping people well through preventive medicine is certainly a more desirable goal than the emphasis in the present system on getting sick people well. But desirable though it may be, how does the medical care system adjust to accomplish it? Such valuable screening devices as pap smears, electrocardiograms, and chest X-rays do not prevent disease, but diagnose it early in its course, when it can be managed better. The disease remains episodic.

I want to make it clear that I am not downgrading the health supervision concept, nor the routine screening examinations. They can be valuable and quite literally lifesaving in the case of the individual patient. But the fact remains that they identify illness. The population at large will continue to get sick, and will continue to be cared for on an episodic basis, pending

some really spectacular breakthrough in preventive medicine.

Fourth, there are people in this country—not a majority, but a lot of people—who cannot afford care. Something has to be done for these people and only government has the funding power to do it.

But fifth is the converse. The majority of the population is perfectly able to finance its own care, except in the truly catastrophic instance. And while catastrophic episodes potentially affect nearly everyone, they actually affect relatively few. This makes it quite feasible to eliminate catastrophic illness as a source of financial catastrophe. Eliminating illness as a source of financial inconvenience is quite another matter. It may or may not be possible to raise enough tax revenues to achieve that. If it is, it will have a considerable impact both on the American concept of taxation, and upon the other activities that government is expected to undertake.

Sixth, there are very real problems of availability, access, and quality, and these have to be solved. I do not think they can be solved by fiat. They will have to be worked out by a system of priority and incentive, and they will need an implementing mechanism that is conversant with and able to deal with circumstances at the local level. If we have learned anything about the financing and delivery of services, it is that there is no one system that is universally satisfactory in all circumstances.

Seventh, and finally, private health carriers are a mixed lot. Some have great potential for effective, economical service in support of health priorities, and some do not. The competitive relationship between carriers has always been advantageous to the public, and there is no reason to think that it would not be advantageous in the future. But the conditions of competition will change. Price competition made possible only by substandard benefits and minimal administration has no place in the financing system of the future. Qualification of the carriers and increased regulation is, in my opinion, necessary, desirable and therefore inevitable.

Against these assumptions, it's possible to draw many conclusions. A few of them are that there is going to be a restructuring of health care financing in this country, combining the capacities of public and private financing, and public and private administration. This restructuring began in 1966 with Medicare and Medicaid, and will be expanded considerably in the next few years. It can be expected to have some fairly specific characteristics. It will provide financing for the poor and the medically indigent — indigent in this case defined broadly enough to include the normally self-sufficient with catastrophic expense. It will keep financing for the majority of the population in the private sector, but will set minimum standards for the scope and level of coverage, and will eliminate those carriers unable or unwilling to cope with the demands of quality coverage at low administrative cost, and of national health policy. Economy and efficiency in medical care will become an even more visible issue, and public surveillance will be substantially greater than it is now. There will be massive experimentation in the delivery of care, and the legislative and funding power of government will be behind that experimentation. The distribution, supply and function of health manpower will be recognized to a much greater extent than now as a direct cost of personal health care, and funded and managed accordingly.

I would suggest that if and when the national health priorities are sorted out, and if and when we achieve some reasonable alignment between what we want and what we're willing to do to get it, we will still need a bridge — an implementing mechanism. And I am hopeful that Blue Cross and Blue Shield, as the pre-eminent and, I sincerely believe, the most knowledgeable and best-motivated organizations for financing, can and will move into this role.

What's needed very badly are agencies that combine the capacity and expertise needed to deal with the problems; a sympathetic understanding of the goals of patients and providers; and, as much as anything, an understanding of the realities of health care. Only the realistic approaches that come from experience are likely to produce acceptable results, instead of overpromise, disillusionment, and frustration.

I think a learning process is taking place. We are learning to operate really big-scale, broad-scope programs in conjunction with government, which we really didn't know how to do five years ago, despite our good intentions. And government is learning, too. Very substantial support has developed for the use of the private sector in the solution of social problems. There is a concrete example in the HMO concept, in which the goals of economy, coordination, availability, and quality are specified, while the method, within limits, is left to the private sector.

There are many needs in the health care field that the carriers can't meet. But there are also a great many things that we can do, and should be doing.

We cannot increase the supply of professional and paraprofessional personnel. But we can

recognize and finance new and better uses of people, and be a positive influence in developing new fields.

We cannot redistribute health personnel. But we can implement incentives as they are funded, and we can promote organizational changes to deal with the problem.

We cannot set standards of quality. But we can make computer screens and review processes available to identify and support it.

We cannot do health planning. But we can finance it, and give it the leverage it needs to be successful.

We cannot generate funds for the poor. But we can channel and administer those funds, and assure that the poor are absorbed into the mainstream of medical care.

And we cannot reorganize the health system. But we can and are providing motivation; expertise; and administrative, marketing, financing, professional relations, and data collection bases for reorganization efforts.

Our purpose has to be a more effective health system. There is a strong temptation to say that if we don't, the government will. This may be true, but it is the wrong reason for the right action. The basic reasons are because we are in business to contribute to better health care—there is no other acceptable reason for our existence — and because we have invested enough time and other people's money in experience that we are literally a national resource. The job cannot be done better without us.

It is often pointed out, although it is not strictly true, that the United States is the only advanced nation in the world without a government system for financing health services. But the United States is also the only nation that has built a strong effective financing system for the majority of its people in the private sector. We are hearing how that system has failed. It has not yet successfully coped with the new demands of the 1970s, but it has not failed. In your mail rooms this morning are unsolicited letters from subscribers telling you that you have dealt extremely effectively with their very real problems today.

You should be very proud of what Blue Cross and Blue Shield are, and what they have done. But you should not be satisfied. The situation is something like what Dickens described as the best of times and the worst of times. There have never been more pressures, more criticism, and more outright threat to our existence, but there have never been more opportunities.



**Pre-Sate®**
**(chlorphentermine HCl)**
**CAUTION:** Federal law prohibits dispensing without prescription.
**Indications:** Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
**Contraindications:** Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
**Warnings:** When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
**Drug Dependence:** Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
**Usage In Pregnancy:** The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
**Usage In Children:** Not recommended for use in children under 12 years of age.
**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
**Adverse Reactions: Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
**Dosage and Administration:** The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
**Overdosage: Manifestations:** Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
**Management:** Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
**How Supplied:** Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
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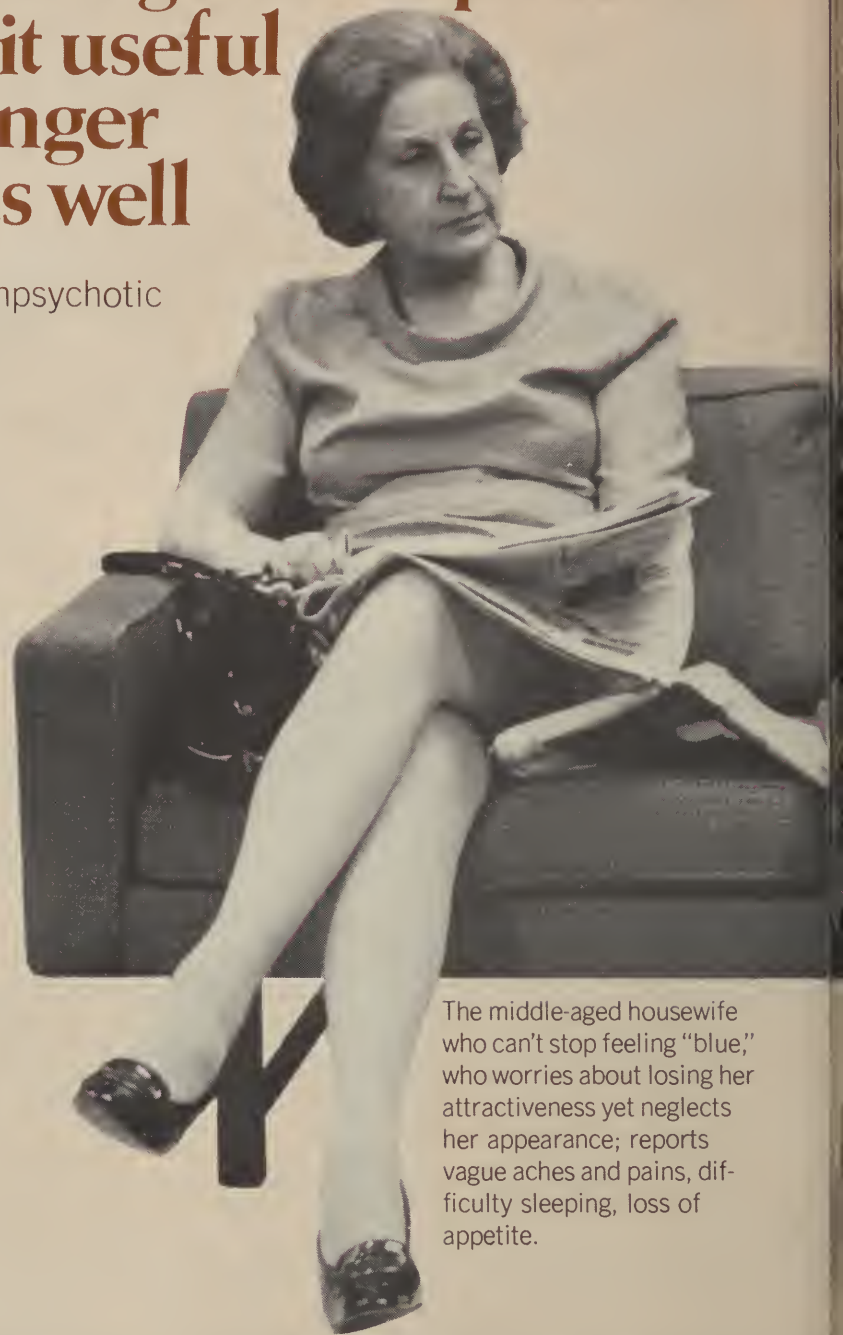
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# What makes 'Deprol' useful for depressed geriatric patients... makes it useful for younger patients as well

- helps ease mild to moderate nonpsychotic depression *and* related anxiety
- helps assure a good night's rest



The middle-aged housewife who can't stop feeling "blue," who worries about losing her attractiveness yet neglects her appearance; reports vague aches and pains, difficulty sleeping, loss of appetite.

**INDICATIONS:** Useful in the management of depression, both acute (reactive) and chronic; particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination; also useful for management of depression and associated anxiety accompanying or related to organic illnesses.
**CONTRAINDICATIONS: Benactyzine hydrochloride:** Glaucoma and previous allergic or idiosyncratic reactions to benactyzine hydrochloride or related compounds. **Meprobamate:** Acute intermittent porphyria and allergic or idiosyncratic reactions to meprobamate or related compounds such as carisoprodol, mebutamate, tybamate, carbromal.
**WARNINGS:** The following information on meprobamate pertains to 'Deprol' (meprobamate + benactyzine hydrochloride): **Meprobamate:** *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, then gradually withdraw. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between meprobamate, alcohol, and other CNS depressants or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. Animal data at five times the maximum recommended human dose show reduction in litter size due to resorption. Meprobamate appears in umbilical cord blood at or near maternal plasma levels, and in breast milk at levels 2-4 times that of maternal plasma. *Children Under Six:* Drug not recommended.
**PRECAUTIONS: Meprobamate:** To avoid oversedation, use lowest effective dose, particularly in elderly and/or debilitated patients. Consider possibility of suicide attempts; dispense least amount of drug feasible at any one time. To avoid excess accumulation, use caution in patients with compromised liver or kidney function. Meprobamate may precipitate seizures in epileptics.
**ADVERSE REACTIONS:** Nausea, dry mouth, other g.i. symptoms; syncope; one case each of severe nervousness and loss of power of concentration. The following side effects, which have occurred after administration of its components alone, have either occurred or might occur when the combination is taken. **Benactyzine hydrochloride:** Benactyzine hydrochloride alone, particularly in high dosage, may produce dizziness, thought blocking, a sense of depersonalization, aggravation of anxiety, or distur

When mild depression and associated anxiety interfere with living

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(meprobamate 400 mg + benactyzine hydrochloride 1 mg)



The junior executive crushed by his repeated failure to be promoted and anxious about the future; complains to you of listlessness, early-morning awakening.

The young widow whose grief has persisted too long, is pessimistic and fearful about what lies ahead, has lost interest in everything; is preoccupied with vague physical ailments, has crying spells.

ance of sleep patterns, and a subjective feeling of muscle relaxation. here may also be anticholinergic effects such as blurred vision, dryness f mouth, or failure of visual accommodation. Other reported side effects ave included gastric distress, allergic response, ataxia, and euphoria. **Meprobamate:** *Central Nervous System:* Drowsiness, ataxia, dizziness, lurred speech, headache, vertigo, weakness, paresthesias, impairment of isual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: tchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.

**USUAL ADULT DOSAGE:** One tablet three or four times daily, which may be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended.

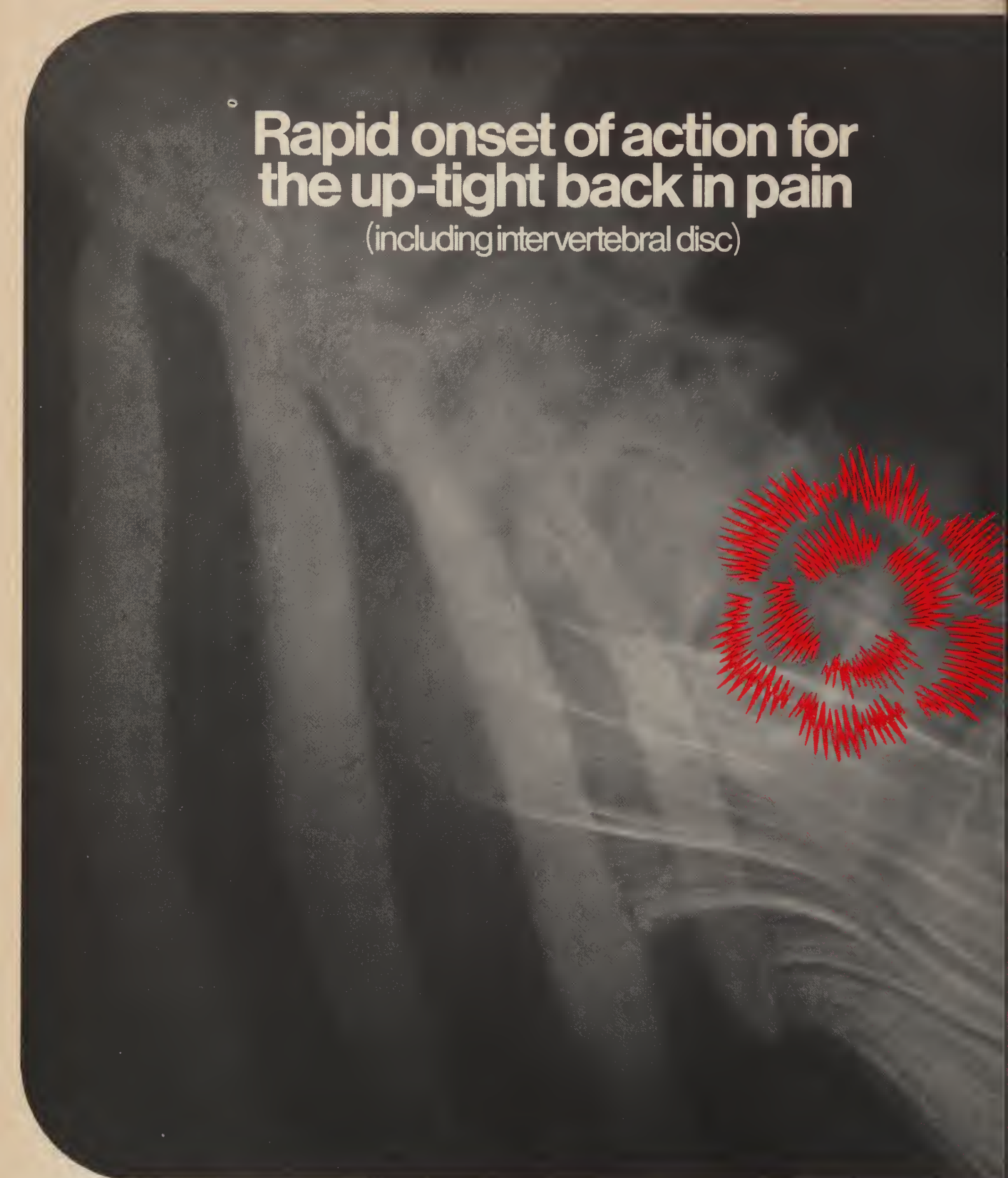
**OVERDOSAGE:** Overdosage of 'Deprol' (meprobamate + benactyzine hydrochloride) has not differed substantially from meprobamate overdosage: **Meprobamate:** Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10/71

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## (including intervertebral disc)



**Indications:** For symptomatic relief in conditions characterized by skeletal muscle spasm and mild to moderate pain.
**Contraindications:** Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.
**Warnings:** *Idiosyncratic Reactions:* Rarely, first dose has been followed by extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion, disorientation. Symptoms usually subside during the next several hours. Supportive and symptomatic therapy, including hospitalization, may be necessary. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. *Children Under Five:* Drug not recommended. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between carisoprodol, alcohol, and other CNS depressants or psychotropic drugs. *Drug Dependence:* Use cautiously in addiction-prone patients.
**Precautions:** To avoid excess accumulation, use caution in patients with compromised liver or kidney function.
**Adverse Reactions:** *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia. *Allergic or Idiosyncratic:* Usually seen after 1-4 doses in patients not previously exposed, e.g., rash, erythema multiforme, pruritus, eosinophilia, fixed drug

# Soma® 350
## (carisoprodol)

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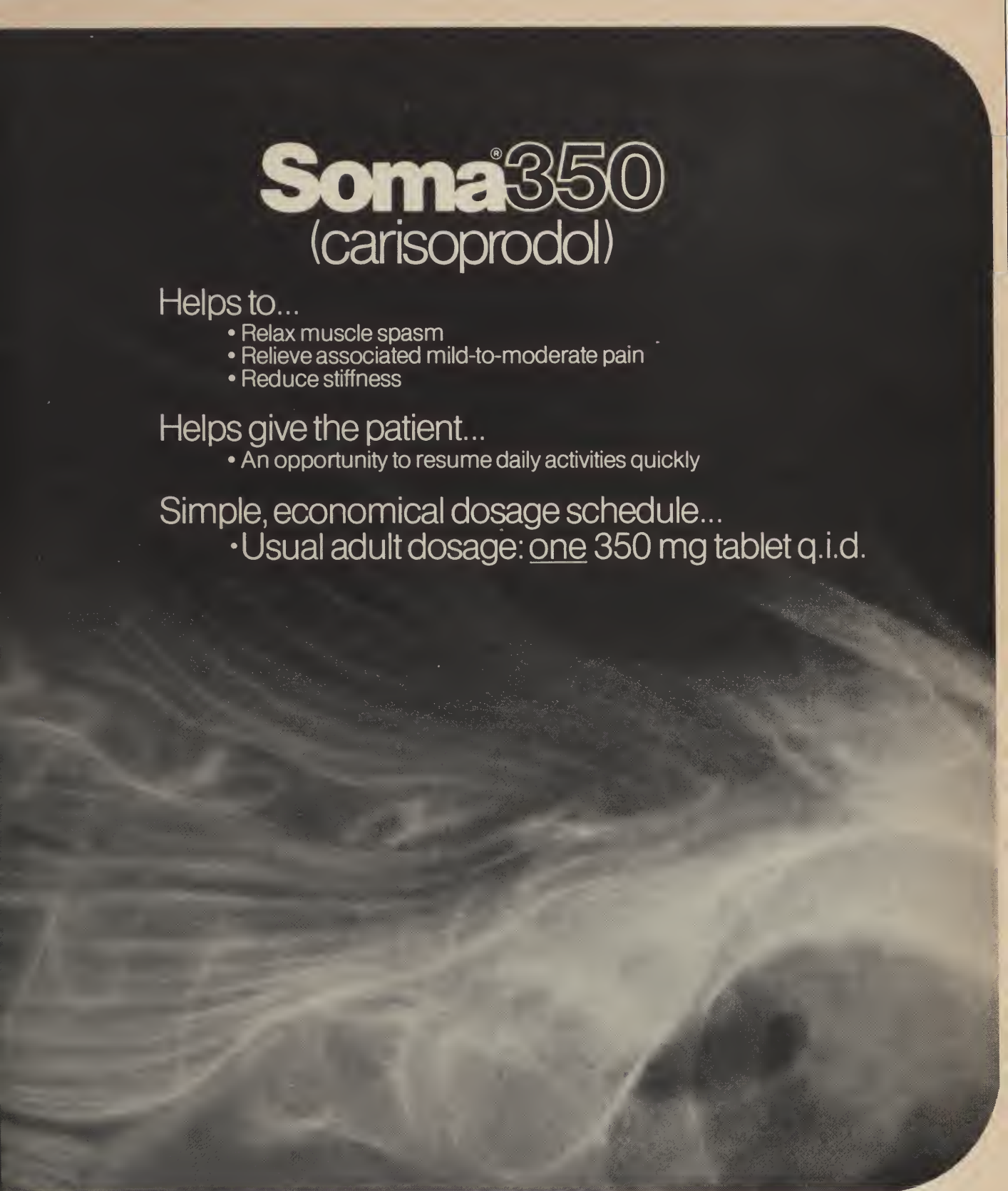
- Relax muscle spasm
- Relieve associated mild-to-moderate pain
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Helps give the patient...

- An opportunity to resume daily activities quickly

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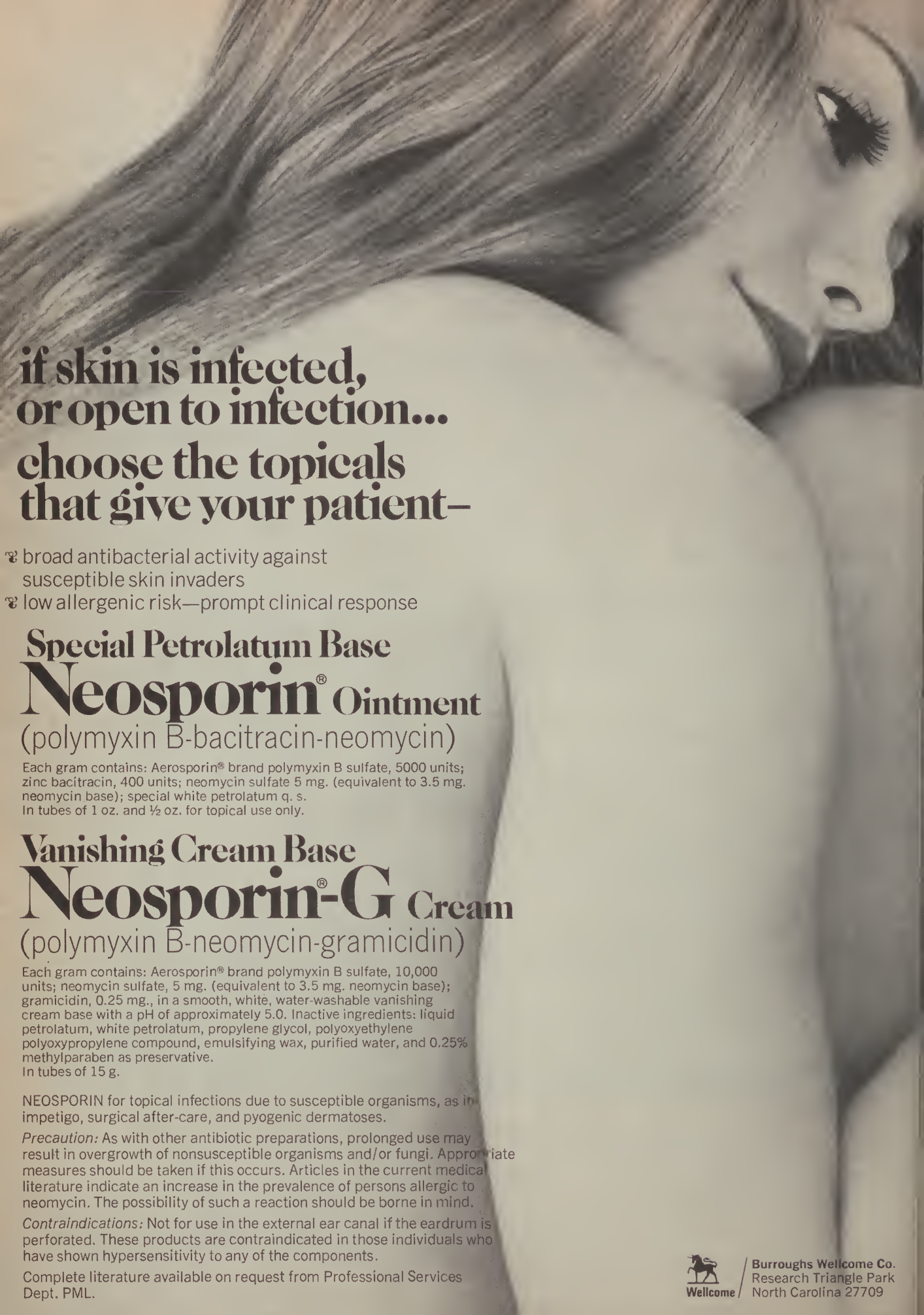


eruption with cross reaction to meprobamate. More severe manifestations: asthma, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension, anaphylactoid shock. Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Cardiovascular:* Tachycardia, postural hypotension, facial flushing. *Gastrointestinal:* Nausea, vomiting, hiccup, epigastric distress. *Hematologic:* Leukopenia and pancytopenia (on carisoprodol plus other drugs).

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**Overdosage:** Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. Overdosage of carisoprodol plus alcohol or other CNS depressants or psychotropic drugs can be additive. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10/71

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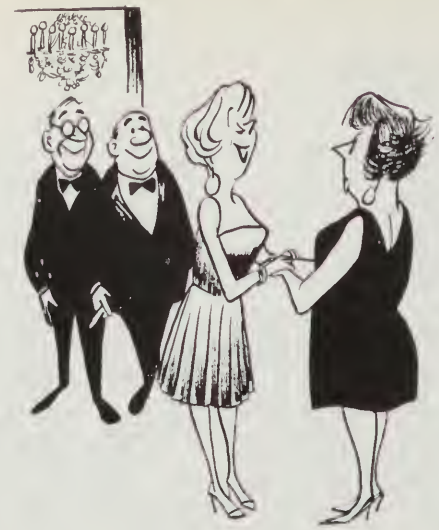
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*Koch-Weser, J., *et al.*: *Arch. Intern. Med.*, *128*:399, 1971.

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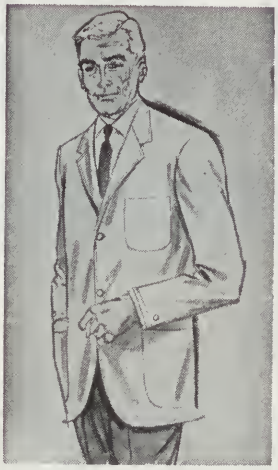
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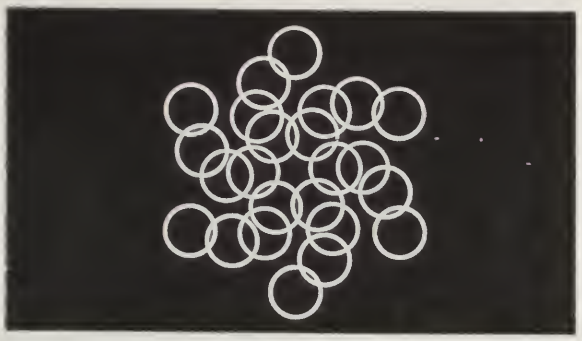
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

# CURRENT STATUS OF THE TREATMENT OF ALCOHOLISM

**MAXWELL N. WEISMAN, MD**
**Director, Division of Alcoholism Control**
**Maryland State Department of Mental Health**

*This presentation was originally made at the Alcohol Safety Action Project Leadership Workshop, Central Missouri State College, December 1971.*

While there is much to learn about alcoholism, we already know enough about the disease and its treatment to be able to help the vast majority of its victims recover if it is diagnosed early. This statement, which may be startling to some, receives ample verification when one examines the recent data emerging from industrial programs. Apart from these however the track record of the involved professionals is notoriously bad! Why should this be so?

Before tearing this question apart, it is important to discuss another aspect. What is the criterion for recovery? Is it a return to the standards of premorbid functioning? For most alcoholics this would clearly be a desideratum. In most such individuals there is ample evidence that falling victim to the disease resulted in multiple difficulties. In fact, this may be circular reasoning since deterioration in some aspect of function or behavior is built into most definitions of the disease. Thus, Alcoholics Anonymous states that the alcoholic is distinguished from the normal, social drinker in that the former's life has become unmanageable to any degree because of alcohol. Likewise, Maryland's Comprehensive Intoxication and Alcoholism Control Law, which became effective July 1, 1968, states in part: "The term chronic alcoholic means any person who chronically and habitually uses alcoholic beverages to the extent that it injures his health or substantially interferes with his social or economic functioning or to the extent that he has lost the power of self-control with respect to the use of such beverages." Recovery then would imply a return to health or one's normal social or economic functioning.

Since poisoning by alcohol (literally, intoxication) is the condition associated with interference of function, it follows that the prevention of intoxication is the *sine qua non* of treatment. Regaining power of self-control resulting in the ability to stop drinking before intoxication would likewise represent recovery, in fact could be called "curing" alcoholism. The clinical experience of thousands of alcoholics however reveals that this condition has not been

achieved, although there are rare exceptions. Although research experiments are now being carried out to teach or condition alcoholics for returning to controlled drinking, for all practical purposes these cannot as yet be applied on any large scale. The only way clinicians, at present, are able to help a patient achieve recovery from his illness is through abstinence and thus guarantee a condition of sobriety.

Even in those relatively fewer alcoholics in whom the disease may be secondary to some deep underlying emotional disorders, coping with the latter does not seem to result in the ability to control the use of alcoholic beverages. Alcoholism may obscure the primary illness and thus change a maladaptive state to what seems to be positive adaptation until it becomes evident that the alcoholism is an entity in itself and also maladaptive. Since the symptoms of the primary disease cannot be worked through when the patient is drinking and intoxicated, the optimum goal of treatment here is sobriety and abstinence.

Why is it so difficult then to help the alcoholic patient achieve abstinence? It can be stated categorically that the greatest stumbling block to treatment lies in the attitude of the treater and the treated! Both, after all, reflect the prevailing views of society and both, each in his own way, are victims of destructive relationships which are inimical to recovery from alcoholism. Before anyone can understand the problems inherent in treating alcoholism, such attitudes must be explored.

The American Medical Association, in 1956, issued a policy statement declaring that alcoholism is a disease and that the physician should be involved in treating it. The following year the American Hospital Association issued a similar statement with respect to the role of general hospitals. In most states this is far from actual practice. Many physicians have had little or no training or experience in treating alcoholics and they sedulously ignore the recommendations of their professional society. Many general hospitals will refuse to admit a patient under the diagnosis of alcoholism. Many physicians do not regard alcoholism as a disease but consider it a lapse from morality, a sign of moral weakness. It follows logically then that is outside his purview as a physician. The hospital administrator disapproves of admitting alcoholics because "there are so many *really* sick people who need our beds." But since alcoholism is a fatal disease, can one generalize and say that alcoholics are not sick or that patients with other diagnosis are *more* sick?

Unfortunately the alcoholic comes to the professional with a deep sense of shame and a feeling of guilt because he shares in society's view of the alcoholic as weak and worthless. When, even in the very first contact, the "helping" person, the therapist, reflects back to him these same feelings there can be little hope of recovery. The alcoholic will be confirmed in his feelings of humiliation and hopelessness.

The physician who is reluctant to place the diagnosis of alcoholism on his patient's chart because it would be "unkind" to the patient perpetuates the social stigma surrounding the disease and prevents the patient from recognizing it as a disease and seeking early treatment. It should be clear that its diagnosis as a disease is no more unkind than that of cancer, diabetes, or tuberculosis. On the contrary, an early diagnosis may be life saving!

The nurse in the emergency room who sees the patient returning again and again in relapse with a serious life-threatening symptom of his illness, intoxication, and looks upon the patient with a serious life-threatening symptom of his not you *again!*" may be sending that patient away to his death, too ashamed to return for help. Yet she doesn't find it reprehensible when the asthmatic returns time and again for treatment of his or her acute symptoms!

In each case the professional person reveals an attitude which is distorted by prejudice and which can be harmful in any treatment relationship.

The therapist must have a deep conviction that alcoholism is a disease. He must be genuinely convinced that the patient is no more responsible for having contracted alcoholism than if he had fallen victim to diabetes. This does not mean that the alcoholic is not responsible for his own treatment. Once diagnosed, his responsibility for remaining on his alcohol-free diet is as great as that of the diabetic, once diagnosed, for remaining on *his* diet. There is, of course, a vast difference in the irresponsibility of society in making it more difficult for the alcoholic to keep to his diet than the diabetic to his!

The therapist must recognize that neither he nor anyone knows why his patient succumbed to alcoholism. To think that he can attribute his patient's alcoholism to some specific etiology, whether biological, psychological, or moral is, in the present state of our lack of knowledge, the height of arrogance. He must come to realize that the majority of alcoholics seem to develop alcoholism gradually while carrying on the normal social drinking behavior which, often, the

therapist himself is indulging in. What precisely happens which results in a loss of control over drinking alcoholic beverages is still obscure.

The therapist must learn to deal with his own feelings of frustration in the face of frequent recidivism and must be willing to keep on treating in spite of what he may feel like calling his patient's "lack of motivation."

He must constantly remain sensitive to his own "lack of motivation" to treat and instead recognize the cry for help in a desperately sick individual who constantly tests the support and love of his therapist by self-defeating resistance to utilizing such help.

Treatment and rehabilitation of alcoholics in almost every state in the country has historically been rooted in state mental hospitals. In Maryland, for example, this pattern is being reversed and the practice initiated of treating alcoholic patients in their local communities. Local health departments have accepted the responsibility for organizing and implementing comprehensive treatment and rehabilitation services.

### Medical Treatment

A model local program includes medical treatment of the acutely intoxicated patient in the emergency room of a general hospital and, if indicated, as an inpatient. Alcoholism counselors have been added to many of the major general hospitals to work in the wards in direct contact with patients with primary or secondary alcoholism diagnoses as well as with those with incipient problem drinking. The expectation is that every general hospital will add alcoholism counselors to its staff.

To relieve the hospital of those homeless alcoholics not sick enough to be admitted, but too sick to be turned out into the streets, a private facility termed a quarter-way house has been found useful. After detoxification in the emergency room, patients may stay here up to 14 days receiving whatever care and medication the hospital physician prescribes; they also receive intensive counseling and guidance into ongoing treatment for the chronic disease. Here the patient may come in contact with an Alcoholics Anonymous meeting, and the spouse, who is called in, with an Al-Anon meeting for the first time.

### Alcoholism Clinics

Alcoholism clinics for patients and families of patients may be outpatient facilities under the auspices of the general hospitals or operated by local health departments. Some may be in neighborhood health centers or in settlement houses or the newer, store-front centers in other communities. They should all be linked however with other services and a local alcoholism coordinator, often on the local health department's staff, should provide this function.

Numerous treatment modalities are available to the physician and his allies, either in the clinic setting or in a private office. These include the use of *Antabuse* (disulfiram) or other chemotherapy, psychotherapy, or counseling, individually or in peer groups, hypnotherapy, aversion treatment, and operant conditioning. There is not, as yet, any specific treatment for alcoholism but each patient must be evaluated individually for a program of care and follow-up that is actually lifelong.

### Half-way Houses

Alcoholics motivated towards sobriety often need a temporary "dry island" to stabilize their recovery. They can benefit by the protective and encouraging environment which a half-way house (for men or women) can provide. While residing in such facilities, most work and pay board, spending their evenings at AA meetings or in counseling and educational groups. Most half-way houses are operated by private, nonprofit corporations in many parts of the country but some are supported by tax funds.

### Shelters for Homeless

In most states, such as in Maryland, where public intoxication has been removed from the criminal system and the public health program is responsible for the detoxification of inebriates, it becomes evident that some are "unlikely to recover" as stated in the Maryland Law. "For these," the law states, "supportive services and residential facilities shall be provided so that they may survive in a decent manner."

The alcoholics who need shelters are those who were formerly known as "police court inebriates." They constitute perhaps 5 to 10% of the country's nine million problem drinkers and are the sickest of all because they were so long neglected by health and social agencies, having progressed in many cases to the late stages of alcoholism. Most have rotated through state mental hospitals, frequent detoxification, and clinic programs without benefit and may have been rather arbitrarily diagnosed as "organic brain syndrome." One such shelter in Baltimore, the first in the state, is demonstrating that meeting the social, nutritional, and medical needs of such alcoholics with an appropriate residential program reduces their compulsion to drink and motivates an unknown percentage to sobriety and productive citizenship. One may find that

it is impossible to predict accurately who is a "hopeless alcoholic" or if the concept is indeed valid.

### State Hospital Services

Although community services for alcoholics have increased considerably in the last several years and, with additional funds available under the Hughes Law (PL91-616), will receive further impetus, state hospital alcoholic rehabilitation units will probably remain a treatment resource for many years. These may be four to six weeks or longer of intensive patient treatment for the chronic illness. In many communities however, state mental hospitals will be able to discontinue their specialized programs for alcoholic patients as local public and private rehabilitation programs of a similar character are developed.

### AA, Al-Anon, and Alateen

The single most important resource for alcoholics and their families is the independent fellowship of Alcoholics Anonymous and related organizations. Groups are almost universally available across the country and in many areas are the *only* immediate help of any kind.

### Correctional Programs

Although public intoxication may no longer be a crime in several states, alcoholics may and should be arrested for breaking the law. When intoxicated, alcoholics contribute disproportionately to the criminal record. The President's Commission on Law Enforcement reported a few years ago that 70% of all crimes of violence in this country are committed under the influence of alcohol. Among such criminals, an unknown but large percentage are alcoholics who were in a blackout and could not remember what they had done.

If an alcoholic commits crimes when he is intoxicated, treatment of his alcoholism may provide the only hope of arresting his criminal career. Such treatment should be intensive as long as he is imprisoned and may be made a requirement after his release. Drinking alcoholics engage in a variety of antisocial behavior ranging from disorderly conduct, to traffic offenses, to murder. Under the law they are subject to the same penalties as nonalcoholics. With treatment, the penalty may represent an investment in hope for alcoholics and sobriety.

### Employee Industrial Programs

The most successful alcoholism programs for employees are those in which company management, with trade union cooperation and support, has adopted a policy of encouraging alcoholic employees to seek treatment and rehabilitation. Unfortunately, many companies have no established policy; alcoholism frequently is not detected as the crux of an employee's problem; or if it is recognized, the alcoholic is protected through mistaken kindness, or summarily discharged upon the first evidence of work deterioration. In such instances, the employer unwittingly contributes to delayed treatment and development or continuation of a chronic illness.

Several leading industrial organizations have developed alcoholism policies and procedures for coping with poor job performance related to drinking problems. Management and labor cooperate in counseling and referral services and coordinate utilization of resources within the organization and the community.

No discussion of treatment can be complete without focusing on prevention. So far as we know today, alcohol education cannot prevent alcoholism — the complex causes of which are still unknown. There is in American society however a great need for clear guidelines to drinking practices and for information about the early symptoms of alcoholism. In a drinking society, young people must find responsible answers to questions about drinking or abstaining and, if the decision is to drink, they must learn how, when, with whom, what, and how much to drink.

Present guidelines for youth about drinking are confusing and contradictory, ranging from the slick advertisements of the liquor industry to the evangelistic tracts of the still energetic temperance movement. Adult models provide little clarification for young people and the patchwork quilt of different control laws confound the confusion.

Teachers must be trained to be more effective in presenting this complex and often controversial subject. Teacher training courses should be designed to encourage teachers to explore family, peer group, and community attitudes toward alcoholic beverages and the drinking and nondrinking practices to which they have been exposed. In training sessions, teachers should consider the nature of their own knowledge of alcohol and alcoholism and thereby gain better understanding of the context within which their students learn. Participants must be helped to clarify their own attitudes toward alcoholic beverages — their use, non-use, and abuse — and to arrive at an understanding of what constitutes for themselves a responsible relationship to alcohol. Then — and only then — can one begin to help students make responsible decisions concerning the role of alcoholic beverages in their lives.

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## RAPID DRUG ALERT INFORMATION

As of January 1, the Medical and Chirurgical Faculty Library subscribes to *Clin-Alert*. *Clin-Alert* is an airmailed up-to-the-minute bulletin that attempts to bridge the gap between the first documented occurrence of adverse drug reactions and the much later dissemination of such information through regular channels. Its purpose is to acquaint the physician and others with published data relevant to exceptional situations encountered in the use of modern therapeutic agents and procedures. While the emphasis is on drug reactions (and interactions), consideration is also given to related material, including legal actions and court decisions when appropriate. Alerts may come from large well controlled studies or arise from the accumulation of widely scattered individual observations. *Clin-Alert* is a worldwide clearing house for such disclosures and will help the library in providing up-to-the-minute information on drug therapy. Members of the Medical and Chirurgical Faculty are encouraged to make use of this service.

## NEW BIBLIOGRAPHIES

The library recently did a bibliography on the subject, **Corporate practice, prepaid medical care, and health insurance.** This bibliography lists 54 recent books, articles, and pamphlets on these subjects, available at the Medical and Chirurgical Faculty Library. A copy of this bibliography is available on request from the library. It is free to Faculty members, $1 to others.

Other bibliographies compiled recently include the following subjects:

Arrhenoblastoma
Diseases caused by microwave ovens
Head trauma and safety helmets
Heany's technique for vaginal hysterectomy
Hemoglobin electrophoresis patterns . . .
Hemoglobin electrophoresis and peptic ulcer
Rheumatic fever prevention and control

## LIBRARY MEETINGS—BALTIMORE, MARYLAND, AND NATIONAL

**Baltimore Hospital Librarians Association**

March 16, 1972 — Church Home and Hospital, Baltimore
Thursday

Hostess: Mrs. Pat Wess, Librarian, Nursing School Library

Subject: Multi-media materials and equipment — Services, sources, and purposes.

May 18, 1972 — Cylburn Park Mansion, 4915 Greenspring Ave. Baltimore (Near Sinai Hospital)
Thursday

Hostess: Mrs. Marlene Ances

Subject: To be planned with relation to some phase of the activities of the park.

**Special Libraries Association, Baltimore Chapter, and National**

Baltimore

March 28, 1972 — Sabatino's Italian Restaurant 901 Fawn St., Baltimore
Tuesday

Subject: Government information resources: survey of federal libraries

Speaker: Miss Susan Geddes
NLM Task Force on Automation

May 1972 — Date for this meeting not yet set.

Probably the annual meeting and attend theater at Morris Mechanic. Watch for announcement.

National SLA

Boston — 1972
Pittsburgh — 1973
Toronto — 1974

**Maryland Library Association**

Annual meeting — April 27-28, 1972 Ocean City, Maryland Headquarters — Convention Hall

**Medical Library Association** — Annual meetings

71st — June 11-15, 1972 San Diego, California

72nd — Kansas City, Missouri — 1973 (dates not set)

73rd — San Antonio, Texas — June 2-6, 1974

(For complete list see the July 1971 issue of MLA Bulletin)

## NEW ACCESSIONS — BOOKS (Arranged by Subjects)

### ANESTHESIOLOGY

Lee, John Alfred

**A synopsis of anaesthesia.** By J. Alfred Lee and R. S. Atkinson. 6th ed. Bristol, J. Wright, 1968. WO 200 .L4 1968.

Wood-Smith, Francis Geoffrey

**Drugs in anaesthetie practice.** By F. G. Wood-Smith, H. C. Stewart, and M. D. Vickers. 3rd ed. N. Y. Appleton-Century-Crofts, 1968. QV 81 .W6 1968.

**Year book of anesthesia.** Year Book Medical Publishers, 1971. WO 275 Y4 1971.

### DIAGNOSIS

MacBryde, Cyril Mitchell

**Signs and symptoms; applied pathologie physiology and clinieal interpretation.** Edited by C. M. MacBryde and Robert Stanley Blacklow. 5th ed. Philadelphia, Lippincott, 1970. WB 141 .M2 1970.

### EMBRYOLOGY

Detwiler, Samuel Randall

**Neuroembryology; an experimental study.** N. Y., Hafner Pub. Co., 1964. WL 101 .D4 1964.

### FAMILY PLANNING

**Advanees in planned parenthood.** Volumes 2-6, 1965-1970. Proceedings of the annual meetings of the American Association of Planned Parenthood Physicians. N. Y., Excerpta Medica. HQ 763 A2.

### GENETICS

Slater, Eliot

**The geneties of mental disorders.** By Eliot Slater and Valerie Cowie. N. Y., Oxford University Press, 1971. WM 300 .S5 1971.

### HERNIA

Zimmerman, Leo M.

**Anatomy and surgery of hernia.** By L. M. Zimmerman and Barry J. Anson. 2d ed. Balto., Williams & Wilkins, 1967. WI 950 .Z5 1967.

### HISTORY OF MEDICINE

Hodges, Paul Chesley

**The life and times of Emil H. Grubbe.** Chicago, University of Chicago Press, 1964. History WZ 100 G7 1964.

Isler, Hansruedi

**Thomas Willis, 1621-1675; doctor and seientist.** Translated by the author. N. Y., Hafner Pub. Co., 1968. History WZ 100 .W5 1968.

Lee, John Alfred

**Notes on the history of anaesthesia.** By J. A. Lee and R. S. Atkinson. Bristol, J. Wright, 1968. WO 200 .L4 1968.

Leibowitz, Joshua O.

**The history of coronary heart disease.** Berkeley, University of California Press, 1970. History WG 300 .L4 1970.

Zimmerman, Leo M.

**Hernia through the ages.** By L. M. Zimmerman and Barry J. Anson. Williams & Wilkins, 1967. WI 950 .Z5 1967.

### HYSTERIA

Janet, Pierre

**The major symptoms of hysteria.** Fifteen lectures given in the Medical School of Harvard University. 2d ed., with new matter. Facsim. of 1929 ed. N. Y., Hafner Pub. Co., 1965. WM 173 J3 1965.

### KIDNEY DISEASES

Lang, Erich K.

**The roentgenographic diagnosis of renal mass lesions.** St. Louis, W. H. Green, 1971. WJ 300 .L2 1971.

### MENTAL HEALTH

Panzetta, Anthony F.

**Community mental health: myth and reality.** Foreword by C. Knight Aldrich. Philadelphia, Lea & Febiger, 1971. WM 58 P3 1971.

### MONITORING SYSTEMS

**Patient monitoring.** Edited by J. F. Crul and J. P. Payne. Baltimore, Williams & Wilkins, 1970 WB 141 .P3 1970.

### OPHTHALMOLOGY

Havener, William H.

**Synopsis of ophthalmology.** 3d ed. St. Louis, C. V. Mosby Co., 1971 WW 100 .H2 1971.

### PAIN

Hardy, James Daniel

**Pain sensations and reactions.** By James D. Hardy, Harold G. Wolff and Helen Goodell. With a foreword by Edwin G. Boring. N. Y., Hafner Pub. Co., 1967. QP 401 .H2 1967.

### PEDIATRICS

**Advances in pediatries.** Volume 18, 1971. N. Y., Year Book Medical Publishers. WS 200 A4 1971.

PHYSIOLOGY
Konorski, Jerzy
**Conditioned reflexes and neuron organization.** Translated from the Polish by Stephen Garry. Facsim. reprint of 1948 ed., with new foreword and supplementary chapter. N. Y., Hafner Pub. Co., 1968. WL 106 K6 1968.

PUBLIC RELATIONS
Public Relations Society of America, Inc.
**Public Relations Register.** 22 ed., 1971. HM 263 P8 1971.

PSYCHOLOGY
Troland, Leonard Thompson
**The fundamentals of human motivation.** N. Y., Hafner Pub. Co., 1967. BF 683 T7 1967.

THORACOSCOPY
Jepson, Otto
**Mediastinoscopy, bioptic mediastinal exploration by the method of Carlens.** Copenhagen, Munksgaard, 1966. WF 900. J4 1966.

VAGOTOMY
Williams, John Alexander
**After vagotomy.** Edited by J. S. Williams and Alan G. Cox. N. Y., Appleton-Century-Crofts, 1969. WL 330 .W5 1969.

BIBLIOGRAPHIES
**Bibliography on smoking and health.** Washington, D. C., U. S. Department of Health, Education, and Welfare, 1970. ZHV 5732 B5.
**The Publishers trade list annual. Books in print.** N. Y., R. R. Bowker, 1971. Ref. Z 1215 .P8.


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ROBERT E. FARBER, MD, MPH, COMMISSIONER

**Baltimore City health department**

# HEALTH HIGHLIGHTS FOR 1971

An almost perfect record of protective inoculations against diphtheria, whooping cough, and tetanus in Baltimore children through age 14 and 11 cases of child lead paint poisoning, the lowest number in 24 years, are two of several notable events in Baltimore's public health picture in 1971, according to a year-end review released by Robert E. Farber, MD, Commissioner of Health of Baltimore City.

New active cases of tuberculosis were down by about 7% from 1970's total of 493, another major advance; likewise, the city experienced sharp declines in measles and German measles.

The year was also noteworthy in that for the first time on record not a single person in Baltimore was ill with typhoid fever.

While these highlights are chiefly the result of long-term public health measures by the nation's oldest local health department, important events have occurred recently in medical care and manpower fields. The year 1971 saw increased activity by the medical profession and private health and medical agencies, assisted by the City Department of Health, in the development of health maintenance organizations or medical service groups which are directing their efforts at filling the need for easily available medical care in city areas where private practitioners are lacking.

The Maryland Consortium for Health Sciences moved ahead in its program of health manpower development in schools. A Medi-School program, jointly sponsored by Dunbar Community High School and The Johns Hopkins Medical Institution, is now in operation. Similarly, curricula are being evolved or adjusted by participating educational institutions to provide allied health specialists through master's degree programs.

Reviewing those concerns evident earlier in the year, the Commissioner has noted progress toward meeting the health needs of Cherry Hill and nearby areas in the groundbreaking of the Cherry Hill Multi-Purpose Center. The center, now under construction, will house major health and social welfare services including a drug abuse unit. Target date for opening is mid-1972.

In those areas of personal health requiring special public health attention, Dr. Farber noted a 50% increase in infectious syphilis from 299 cases in 1970 to 450 cases in 1971, and a continuing inordinately high number of cases of gonorrhea — 11,200 cases in 1971 — both attributed to the increasing sexual permissiveness of our society and an insensitivity on the part of sexually promiscuous individuals to the medical aspects of venereal diseases.

Noting that heart disease and cancer continue as the two leading causes of death with 4,143 and 2,000 deaths respectively, the health commissioner reaffirms leading medical opinion that cigarette smoking has both direct and indirect impact on these killers. In 1971 a total of 484 persons died of lung cancer. Of these 383 were males and 101 were females. However, considering that the number of males far exceeded females in the smoking habit during the early popularization of cigarette smoking, the toll among males currently is understandably higher than females.

If male and female lung cancer death trends are compared, one can see that women are slowly catching up with men. It is reasonable to predict that the number of deaths in women will continue to increase at a faster rate unless smoking habits are modified or eliminated. The following table graphically shows these trends.

**Lung Cancer Deaths By Sex**

| Year | Male | Female | Total |
|---|---|---|---|
| 1931 | 32 | 13 | 45 |
| 1941 | 91 | 16 | 107 |
| 1951 | 173 | 22 | 195 |
| 1961 | 289 | 33 | 322 |
| 1971 | 383 | 101 | 484 |

## OTHER NOTEWORTHY EVENTS

Other noteworthy events for 1971 included the following:

1. **Nutrition**—Continuation of the drive against malnutrition through an iron-enriched milk feeding program for infants in Cherry Hill supplementing a like program in the Model Cities area begun in 1969; nutrition education programs for staff, community agencies, teachers, and residents of all ages; participation in state and national conferences on aging with a focus on nutrition; and professional guidance in the city's summer feeding program.
2. **Mental Health**—Promotion by the City Health Department's Mental Health Advisory Council of the development of adequate mental health service networks throughout the city, and the beginning, through a contract from the State Department of Health and Mental Hygiene, of a program designed to reduce the role of alcohol as a contributing factor in highway accidents. Also, the beginning of a Women's Counseling Alcoholism Group.
3. **Sickle Cell Anemia**—Inauguration of testing for sickle cell trait and sickle cell disease in selected City Health Department clinics and some schools. Hopefully, funds will be made available for testing black children in the senior high schools of the city.
4. **Immunization**—Establishment of follow-through mop-up programs in schools to improve immunization levels for polio, measles, and German measles.
5. **Special Home Services for the Elderly Sick**—Expanded transportation services to medical facilities for medical assistance clients through reimbursement by the State Department of Health and Mental Hygiene, and provision of house-keeping and volunteer services through the addition of 17 additional staff members through the Public Employment Program. Health aides will now wash, iron, cook, clean, shop, and perform other household tasks so that clients can maintain themselves in the community.
6. **New Clinics**—The addition of Broad adult and child health and medical services jointly with Mercy Hospital for residents of South Baltimore at the Southern Health District Building, 1211 Wall Street; the establishment of a Foot Care Clinic in the Western Health District Building, 700 W. Lombard Street, jointly with the Maryland Podiatry Association for persons on medical assistance; and family planning, prenatal, and well baby clinics at the Kirk Community Activity Center, 22nd Street and Kirk Avenue.
7. **Dental Care**—The delivery of the first of six mobile dental units provided through a Model Cities grant. When all units are in operation an estimated 100,000 needy residents will have available comprehensive dental services.
8. **Animal Bites**—Closer cooperation by animal owners in complying with the quarantine regulations in the prevention of rabies resulted in a 65% increase in animals quarantined at the Municipal Shelter or at private locations. A total of 2,700 animals, chiefly dogs, was quarantined in 1971 compared with 1,600 in 1970. Over 7,000 animal bites were reported during the past year.
9. **Vital Records**—Provision through legislation for the amalgamation of the City Health Department's Bureau of Vital Records with the state's Division of Vital Records effective July 1, 1972. Until such times as both units can be centralized in one location, the city's vital records office will continue in the Municipal Building at Lexington and Holliday Streets.

## POPULATION

The estimate of the resident population as of July 1, 1971 is 897,000 persons. This estimate indicates that Baltimore City has continued to lose population with a decline of 7,000 persons between July 1, 1970 and July 1, 1971. This decline is the net result of a drop of 12,000 in the white population from 476,000 to 464,000 persons and an increase of 5,000 in the nonwhite population from 428,000 to 433,000 persons. As of July 1, 1971 the nonwhite population constituted 48.3% of the total population compared to 47.3% on July 1, 1970.

## BIRTHS

An examination of the birth statistics for 1971 shows that the number of live births among city residents has continued to decline. The total of 15,311 resident births is the lowest such figure since 1940. It is 757 or 4.7% below the number registered in 1970 and 7,951 or 34.2% below the number registered in 1960. The birth rate or the number of births per 1,000 city residents was 17.1 compared to 17.8 in 1970, 21.1 in 1965, and 24.1 in 1960.

## DEATHS

There were 10,716 resident deaths reported in 1971, 611 fewer than the 11,327 deaths reported during 1970. The resident death rate per 1,000 population was 11.9 in 1971, 12.5 in 1970 and 12.7 in 1969. Among the white population deaths exceeded births for the fourth consecutive year.

The infant mortality rate, the number of infant deaths per 1,000 live births, is an important

health index. In 1970 the rate was 25.9, the lowest rate ever recorded in Baltimore City. In 1971 there were 408 infant deaths resulting in a slightly higher rate of 26.6 infant deaths per 1,000 live births. In 1971 there were five maternal deaths compared to seven in 1970.

The number of accidental deaths declined from 469 in 1970 to 384 in 1971, a decline of 85 or 18.1%. All categories of accidental deaths showed substantial declines except occupational deaths which increased from 22 in 1970 to 31 in 1971. The largest decline was registered in the home accidents category which fell from 186 in 1970 to 124 in 1971, a decrease of 33.3%.

In 1971 there were 309 resident deaths due to homicide. This represents an increase of 32.1% over the 234 deaths registered in 1970 and an increase of 125.5% over the 137 deaths in 1965. Approximately 60% of all homicide deaths are among persons who are between the ages of 15 to 39 years.

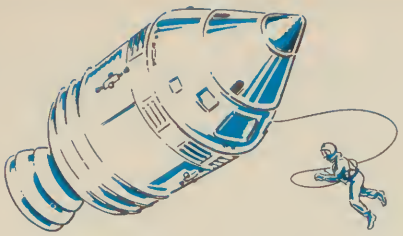
Among the other leading causes of death the statistics for 1971 are as follows: heart disease—4,143, down 294 from 1970; cancer—2,000, down 48; cerebrovascular disease 759, down 45; cirrhosis of liver 333, down 26; diabetes mellitus 323, down 31; congenital malformations and diseases of early infancy 319, up 10; influenza and pneumonia 220; down 85; and suicide 108; up six.




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# SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 3, 4, 5, 1972
Baltimore Civic Center

**Ample space is available, however, it is suggested that applications be submitted as soon as possible.**

## RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

## APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS




**Baltimore City Medical Society**

# Board of Directors Meets

The Board of Directors of the Baltimore City Medical Society met on January 11th. The contract between the State Health Department and the Braxton/Carter Associates was discussed. Earlier it had been reviewed by a special committee of the Society. The contract provides that the Braxton/Carter Associates will be paid on a patient visit basis the sum of $19.73 for providing medical services to Medicaid recipients. The Board aproved the following motion which was sent to the Secretary of Health and Mental Hygiene of the State of Maryland.

Whereas, The State Department of Health and Mental Hygiene has entered into contractual agreements with hospitals and community organizations to support the delivery of comprehensive health services for indigent persons on a prepaid capitation basis, and,

Whereas, The Department has recently contracted with Braxton/Carter Associates, a corporation of physicians, to provide health care to Title XIX eligible persons on a fee-for-patient-visit basis; and

Whereas, The Board of Directors of the Baltimore City Medical Society finds that the fees agreed upon appear to be unusual and excessive for the services delivered, that the service is inexactly defined in the contractual arrangements, and that a mechanism is lacking to analyze and evaluate these experimental contracts in that neither the state nor the providers have experience in the delivery of health care under these circumstances;

Therefore, be it resolved, That the Baltimore City Medical Society Board of Directors calls upon the Secretary of Health and Mental Hygiene to immediately develop effective evaluative systems for this and future contractual agreements. Such evaluative systems must include:

a) fiscal audit to assure the taxpayers of Maryland that the tax monies are expended according to terms of the contract,

b) medical audit to determine that medical conditions are being managed according to accepted norms of good medical practice, and

c) review of quality of medical care by other physicians skilled in the care of ambulatory patients (peer review).

In response to a request that the Society approve of a Hypertention Detection and Follow-up program, the Board determined that a Committee on Review of Research Protocols should be established. The Committee would investigate all protocols submitted to the Board for approval and make appropriate recommendations.

The Board established a policy that protocols presented to the Society for approval must include a procedure for obtaining the informed consent of the patient. It was considered that in some instances, patients might be led to believe that they are receiving "medical care" under research programs. The Board believes that it is the definite responsibility of those performing research activities to inform patients that medical care is not being provided and that patients should consult their own physician for any medical problems.

The Board also discussed the concept of possible lack of communication between the Society and its Faculty representatives. It was reaffirmed that the Bylaws state that it is a responsibiliy of the office of Alternate and Delegate to attend general meetings of the Society so that the physicians holding these positions can adequately represent the members of the Society in the Med-Chi House of Delegates. Other means of communication between Society representatives and the general membership will be explored in the future.

FRANCIS X. CARMODY, MD
Journal Representative

EMERGENCY MEDICAL SERVICES
SECOND ANNUAL SYMPOSIUM

# "THE UNCONSCIOUS PATIENT IN THE EMERGENCY ROOM"

WEDNESDAY, MARCH 22, 1972
at the
Sinai Hospital, Baltimore, Maryland

Sponsored by the **MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND**

| | |
|---|---|
| 8:00 AM | REGISTRATION |
| 8:45 | INTRODUCTORY REMARKS<br>**John F. Schaefer, MD**<br>President, Medical and Chirurgical Faculty |
| 9:00 | FILM — **"EMERGENCY CARE OF ACUTE DRUG OVERDOSAGE"** |
| 9:45 | **HOW I WOULD MANAGE THE UNCONSCIOUS CHILD**<br>**Robert S. Mosser, MD**<br>Assistant Professor of Pediatrics, Neurology<br>University of Maryland School of Medicine |
| 10:30 | INTERMISSION — **VISIT EXHIBITS** |
| 10:50 | **THE UNCONSCIOUS CHILD AS THE NEUROSURGEON SEES HIM**<br>**R.M.N. Crosby, MD**<br>Associate Professor of Neurological Surgery (Pediatric)<br>University of Maryland School of Medicine |
| 11:45 | LUNCH |
| 1:00 PM | **UNCONSCIOUS? IT COULD BE ANYTHING!**<br>**Theodore Goldberg, MD**<br>Director of Medicine and Chief of Cardiology<br>Pascak Valley Hospital<br>Westwood, New Jersey |
| 1:45 | INTERMISSION — **VISIT EXHIBITS** |
| 2:00 | **MANAGEMENT OF THE MULTIPLE INJURED AND COMATOSE PATIENT**<br>**James E. Dunn, II, MD**<br>Assistant Professor of Neurosurgery and<br>Clinical Director, Shock-Trauma Unit<br>University of Maryland School of Medicine |
| 2:45 | **PANEL — WITH ALL SPEAKERS PARTICIPATING** |

ARRANGEMENTS HAVE BEEN MADE AT THE LEVINDALE AND SINAI PARKING LOTS. PRESENT PARKING CHECK AT THE REGISTRATION DESK.

Ad Hoc Planning Committee for Symposium
George H. Greenstein, MD, Chairman

DETACH AND MAIL THE FOLLOWING REGISTRATION FORM **TODAY** TO:

SYMPOSIUM ON THE UNCONSCIOUS PATIENT IN THE EMERGENCY ROOM
Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201

**REGISTRATION INCLUDING LUNCH $5.00**

I plan to attend the symposium on Wednesday, March 22, 1972 at Sinai Hospital, and enclosed is a check* for $..... for registration of #..... persons.

NAME _____ AFFILIATION _____

ADDRESS _____

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***Make checks payable to**
**Medical & Chirurgical Faculty of Maryland**



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Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
University of Maryland, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
Washington County, Hagerstown

**Other locations:**

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Association of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

**For further information contact:**

MEDIC
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872

### March 24, 1972 12:30 PM

### HOST DEFENSE MECHANISMS

**Dexter Seto, MD**
Assistant Professor of Pediatrics
Assistant Professor of Microbiology
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

Replays: Monday, March 27, 1972 12:30 PM
Wednesday, March 29, 1972 9:00 AM
2:00 PM

### March 31, 1972 12:30 PM

### GASTROINTESTINAL BLEEDING

**Vernon M. Smith, MD, FACP**
Professor of Clinical Medicine
University of Maryland School of Medicine
Chief of Gastroenterology
Mercy Hospital

**Sponsor: Mercy Hospital**

Replays: Monday, April 3, 1972 12:30 PM
Wednesday, April 5, 1972 9:00 AM
2:00 PM

### April 7, 1972 12:30 PM

### PRACTICAL ASPECTS OF THE PRACTICE OF NEUROLOGY

**Barbara Hulfish, MD**
Assistant Professor of Neurology in Psychiatry
University of Maryland School of Medicine

**Sponsor: Sacred Heart Hospital**

Replays: Monday, April 10, 1972 12:30 PM
Wednesday, April 12, 1972 9:00 AM
2:00 PM

### April 14, 1972 12:30 PM

### CLINICAL MANAGEMENT—USE OF THE PHYSICIAN'S ASSOCIATE

**John Collins Harvey, MD**
Professor of Medicine
Johns Hopkins University School of Medicine
Executive Vice-President and Medical Director
Good Samaritan Hospital

**Sponsor: Good Samaritan Hospital**

Replays: Monday, April 17, 1972 12:30 PM
Wednesday, April 19, 1972 9:00 AM
2:00 PM

**CONTINUING PROGRAMS**

**(Heard at participating hospitals only)**

**SATURDAY MORNINGS—11:30 AM**

CONJOINT CLINIC
Johns Hopkins University
(September-May)

**TUESDAY MORNINGS—11:30 AM**

MEDICAL GRAND ROUNDS
University of Maryland Hospital
(September-May)

**WEDNESDAYS—12 NOON**

C. P. C.
The Johns Hopkins Hospital
(September-May)

**SATURDAY MORNINGS—10:00 AM**

MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital
(September-May)

**SATURDAY MORNINGS—8:30 AM**

PEDIATRIC GRAND ROUNDS
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**MAY 3, 4, 5, 1972**

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Organization **MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND**
**ANNUAL MEETING: MAY 3, 4, 5, 1972—Baltimore Civic Center**

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HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.




**UNDERSTANDING LABORATORY MEDICINE, by Camilla V. Bologna, MD, The C. V. Mosby Company, St. Louis, 1971.**

The audience to which this book is primarily directed is one consisting of laboratory technicians, nurses, and the other paramedical personnel involved in the handling of laboratory work who do not, in many cases, actually see the patient. It is intended to give these persons an insight into the rationale and other reasons for the burgeoning number of laboratory tests being performed. It serves as a source for basic, conceptual information concerning the laboratory. It does not involve any more methodological material or detail than is necessary to achieve its ends.

**PEDIATRIC THERAPY, by Harry C. Shirkey, MD, The C. V. Mosby Company, St. Louis, 1972.**

The list of contributors to this publication includes and sounds like a Who's Who of those physicians who specialize in pediatrics and related fields. It is the fourth edition of a book published first in 1964. Essentially, it brings up to date the previous editions, with a list of new contributors. A minimum of space is given to diagnosis, maximizing on treatment, thus avoiding the production of a pediatrics "cookbook."

**CURRENT CONCEPTS IN DYSLEXIA, edited by Jack Hartstein, MD, The C. V. Mosby Company, St. Louis, 1971.**

With the recent tremendous interest, both on a local and national level, of this problem, this book fills a timely need. The term itself holds many different meanings for many people. As used in this publication, it means a condition in children with normal intelligence who have learning disorders. The purpose of the book is to provide the reader with both an overall view of the terms, people, and studies involved in evaluation of such children and also to provide the reader with an in-depth discussion from the points of view of the various specialists whose daily job involves them with these problems. It provides an entire perspective of this field as well as the detailed thoughts of various specialists involved in it.

# A PREVIEW OF THE 1972 ANNUAL MEETING PROGRAM
# WEDNESDAY, THURSDAY, FRIDAY
# MAY 3, 4, 5

***ALL MEETINGS AT THE BALTIMORE CIVIC CENTER UNLESS OTHERWISE INDICATED***

## WEDNESDAY, MAY 3

9:30 AM — Meeting of the House of Delegates

12:30 PM — *MMPAC LUNCHEON* Meeting — Baltimore Hilton Hotel
Representative **William R. Roy, MD,** U.S. Representative from Kansas, will speak on *MEDICINE AND LEGISLATIVE TRENDS AS I SEE THEM*

2:00 PM — *PEER REVIEW: PROBLEMS AND POTENTIALS.* J.M.T. Finney Fund Lecture
**Otto C. Page, MD,** President, American Society of Internal Medicine; and Associate Clinical Professor of Medicine, University of Oregon Medical School.
*A PANEL OF MEMBERS OF THE FACULTY'S PEER REVIEW COMMITTEE* will discuss actual cases that have been reviewed and will also present third party involvement.

## THURSDAY, MAY 4

### Concurrent Sessions Cosponsored By Various Specialty Societies

9:30 AM — *BATTERED CHILDREN: NEW CONCEPTS, NEW ACTIONS* — Harvey Grant Beck Memorial Lecture
**Brandt F. Steele, MD,** Professor of Psychiatry, University of Colorado School of Medicine
This lecture will be followed by a panel discussion:
Moderators: **Marvin Cornblath, MD,** Professor and Head, Department of Pediatrics, University of Maryland
**J. Alex Haller, Jr., MD,** Professor of Pediatric Surgery, The Johns Hopkins University
Participants: **Priscilla A. Gilman, MD,** Assistant Professor of Pediatrics, University of Maryland
**Diane Schulte, LLB,** Assistant State's Attorney, Baltimore City
**John P. Dorst, MD,** Professor of Radiology and Head of Pediatric Radiology, The Johns Hopkins University

9:30 AM — *PRACTICAL CONSIDERATION IN DIAGNOSIS AND TREATMENT OF HEART DISEASE* — A panel discussion
Moderator: **Donald H. Dembo, MD,** President, Heart Association of Maryland
Participants: *HYPERTENSION* — **D. Theodore Lewers, MD,** Director of Medical Education and Chairman of Department of Pathology, Maryland General Hospital, Baltimore
*HEART FAILURE* — **Kenneth B. Lewis, MD,** Cardiologist and Director of Department of Medicine, Franklin Square Hospital, Baltimore

*PERIPHERAL VASCULAR DISEASE* — **Robert J. Wilder, MD,** Cardiovascular Service, Sinai Hospital of Baltimore

*SELECTION OF PATIENTS FOR CINE-CORONARY ARTERIOGRAPHY* — **J. Richard Warbasse, MD,** Chief, Cardiovascular Service and Laboratories of the U.S. Public Health Service Hospital, Baltimore

9:30 AM *CYTOTOXIC THERAPY IN RHEUMATOID ARTHRITIS AND SYSTEMIC LUPUS ERYTHEMATOSUS* — Standish McCleary Fund Lecture

**John L. Decker, MD,** Chief of Arthritis and Rheumatism, National Institute of Arthritis and Metabolic Diseases

11:00 AM *THREE DELIVERIES THAT CHANGED THE HISTORY OF THE WORLD* — Hundley Memorial Lecture in Gynecology

**Louis M. Hellman, MD,** Deputy Assistant Secretary for Population Affairs, Department of Health, Education and Welfare

2:30 PM *CURRENT ASPECTS OF CARDIAC SURGERY* — A panel discussion

Moderator: **Joseph S. McLaughlin, MD,** Head of Division of Thoracic and Cardiovascular Surgery, University of Maryland

Participants: *VALVULAR HEART SURGERY* — **Safuh M.A. Attar, MD,** Professor of Thoracic Surgery, University of Maryland

*CONGENITAL HEART DISEASE* — **Stephen Z. Turney, MD,** Assistant profemmssor, Division of Thoracic and Cardiovascular Surgery, University of Maryland

*THE SURGICAL TREATMENT OF MYOCARDIAL INFARCTION SHOCK* — I. Ridgeway Trimble Fund Lecture

**W. Gerald Austen, MD,** Professor of Surgery, Harvard Medical School

2:30 PM *A FUNCTIONAL RESPIRATORY CARE SERVICE* — **Martin I. Gold, MD,** Professor, Department of Anesthesiology and Head, Division of Respiratory Care, University of Maryland

2:30 PM *RAPID RECOGNITION OF SUICIDE AND MODERN MANAGEMENT METHODS* — **Joy Ruth Joffe, MD,** Phipps Clinic, The Johns Hopkins Hospital

*PRESCRIPTION DRUGS, PSYCHOPHARMACOLOGIC PATTERNS IN PRACTICE* — **Jerome Levine, MD,** National Institute of Mental Health

## FRIDAY, MAY 5

### Concurrent Sessions Cosponsored By Various Specialty Societies

9:30 AM *REHABILITATION MEDICINE* — A panel discussion moderated by **B. Stanley Cohen, MD,** President, Maryland Society of Rehabilitation Medicine

*A CURRENT APPROACH TO THE EVALUATION AND MANAGEMENT OF BELL'S PALSY* — **C. James Duke, MD,** Chief, Physical Medicine and Rehabilitation, Holy Cross Hospital, Silver Spring, Maryland

*REHABILITATION AND ACUTE MYOCARDIAL INFARCTION* — **B. Stanley Cohen, MD,** Chief, Department of Rehabilitation Medicine, Sinai Hospital of Baltimore; and Clinical Associate Professor of Rehabilitation Medicine, University of Maryland

*MANAGEMENT OF COMMON NECK PROBLEMS* — **Paul F. Richardson, MD,** Professor and Chairman, Department of Rehabilitation Medicine, University of Maryland

*ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES: PRACTICAL DIAGNOSTIC IMPLICATIONS AND LIMITATIONS* — William Royal Stokes Memorial Lecture

**Joseph Goodgold, MD,** Professor, Director, Research and Training, Department of Rehabilitation Medicine, New York University School of Medicine

9:30 AM *CLINICAL PHARMACY: A NEW PROFESSION* — A panel discussion by members of the staff of the University of Maryland School of Pharmacy

*CHANGING ROLES FOR PHARMACISTS* — **William J. Kinnard, Jr., PhD,** Dean and Professor of Pharmacology and Toxicology

*CLINICAL PHARMACISTS: PRACTICAL CONSULTANTS FOR MDs* — —**Robert** *A.* **Kerr, PharmD,** Instructor in Pharmacy

*WHAT YOU MUST KNOW ABOUT DRUG INTERACTIONS* — **David A. Blake, PhD,** Associate Professor and Chairman, Department of Pharmacology and Toxicology

*DRUG INFORMATION SERVICES, OR WHAT YOU WANT TO KNOW BUT ARE AFRAID TO ASK* — **Peter P. Lamy, PhD,** Associate Professor and Director, Institutional Pharmacy Programs; and **Winifred Sewell, BSLS,** Adjunct Assistant Professor of Pharmacy

*BIOAVAILABILITY AND DRUG PRODUCT DESIGN: IT AFFECTS YOUR PATIENT, YOUR THERAPY!* — **Ralph F. Shangraw, PhD,** Professor and Chairman, Department of Pharmacy

9:30 AM *MEDICAL LEGAL COMPLICATIONS OF INDUSTRIAL MEDICINE* — I. Ridgeway Trimble Fund Lecture

**Charles J. Frankel, MD,** Associate Professor of Surgery, University of Virginia Medical School

11:00 AM *TRANSFER FACTOR THERAPY OF IMMUNO-DEFICIENCY DISEASES* — George M. Boyer, MD, Lecture

**H. Sherwood Lawrence, MD,** Professor of Medicine, and Head of Infectious Disease and Immunology Division, New York University School of Medicine

*DISCUSSANT* — **Sheldon E. Greisman, MD,** Associate Professor of Medicine, University of Maryland

11:00 AM *CURRENT STATUS OF DIABETIC AND SICKLE CELL RETINOPATHIES*

**Arnall Patz, MD,** Director, Diabetic Retinopathy Center, The Johns Hopkins Hospital

2:00 PM *THE PROBLEMS OF MANAGEMENT OF DIABETES IN THE PRESENCE OF OTHER ENDOCRINE DISORDERS*

Harvey Grant Beck Memorial Lecture

**John J. Canary, MD,** Professor of Medicine, and Director of Division of Endocrinology and Metabolic Diseases, Georgetown University

2:00 PM *THE DOCTOR'S LEGAL DILEMMA: PRESENT AND FUTURE* — a medico-legal symposium

2:00 PM *THE TREATMENT OF TRAUMA IN THE 1970s* — A panel discussion

Moderator: **Michael E. Jabaley, MD,** Assistant Professor of Plastic Surgery, The Johns Hopkins University

Participants: *REPUBLIC VIET NAM (RVN) VASCULAR REGISTRY AS A MODEL FOR A TRAUMA REGISTRY* — J.M.T. Finney Fund Lecture

**Norman M. Rich, MD,** Chief of Vascular Surgery, Walter Reed Hospital, Washington, D.C.

*TRIAGE AND INITIAL EVALUATION* — **William P. Sadler, MD,** President, Wicomico County Medical Society, Salisbury, Maryland

*THE ROLE OF SPECIALTY UNITS IN PROBLEMS UNIQUE TO CHILDREN* — **J. Alex Haller, Jr., MD,** Professor of Pediatric Surgery, The Johns Hopkins University

*THE CONCEPT OF A BURN UNIT AND RECENT ADVANCES IN BURN MANAGEMENT* — **Gardner W. Smith, MD,** Surgeon-in-Chief, Baltimore City Hospitals

*THE SHOCK TRAUMA UNIT* — **R Adams Cowley, MD,** Chairman of the Division of Trauma and Program Director of Center for Study of Trauma, University of Maryland Hospital

*THE TREATMENT OF SHOCK* — **T. Crawford McAslan, MD,** Professor of Anesthesiology, University of Maryland

3:15 PM *SKIN MANIFESTATIONS OF INTERNAL MALIGNANT TUMORS* — William Royal Stokes Memorial Lecture

**Helen O. Curth, MD,** Assistant Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University

* * * * * * * * * * * * * *

## SCIENTIFIC AND TECHNICAL EXHIBITS

Many exhibits, both scientific and technical, will be on display at the *Baltimore Civic Center* during the Annual Meeting. **VISIT THESE EXHIBITS AND KEEP ABREAST OF SCIENTIFIC ADVANCEMENT!**

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## OTHER IMPORTANT ANNUAL MEETING ACTIVITIES

**ROUND TABLE LUNCHEON** — Holiday Inn-Downtown

There will be 16 tables at which different subjects will be discussed. All physicians will find a topic of particular interest.

**PRESIDENTIAL RECEPTION AND BANQUET** — Blue Crest North

Delectable food, good music, dancing, a delightful evening for all!

**HOSPITALITY NIGHT** — Baltimore Hilton Hotel

An opportunity for members of the Faculty and their wives to get together with their fellow members as guests of the Faculty for a fun function. A barbershop quartet will add to the enjoyment.

**ART AND HOBBY EXHIBIT** — Baltimore Civic Center

All physicians, their wives, and families are invited to complete the application which appears in the Maryland State Medical Journal, and send to the Faculty office.

**HEALTH EVALUATION TESTS** — Baltimore Civic Center

An opportunity for physicians attending the Annual Meeting to avail themselves of many screening tests. Plan to allow time to take advantage of these procedures offered by fellow physicians.

BE SURE THESE DATES ARE MARKED ON YOUR CALENDAR

**MAY 3, 4, 5, 1972**

John B. De Hoff, MD, Chairman
Committee on Program and Arrangements

# AMONG THE SPEAKERS AT THE 1972 ANNUAL MEETING of the MEDICAL AND CHIRURGICAL FACULTY MAY 3, 4, 5, 1972 BALTIMORE CIVIC CENTER

## DR. PAGE

On Wednesday afternoon, May 3, **Otto C. Page, MD,** President of the American Society of Internal Medicine, will address the plenary session of the Faculty's Annual Meeting on *PEER REVIEW: PROBLEMS AND POTENTIALS.* This will be a **J.M.T. Finney Fund Lecture.**



**Dr. Page**

Dr. Page, a native of Laconia, New Hampshire, is in private practice, specializing in internal medicine and diabetes in Portland, Oregon. He is also Clinical Professor of Medicine at the University of Oregon Medical School. He received his BS degree at Boston University, and his MD degree at Boston University School of Medicine in 1944. He then served internships in Pathology at the Boston City Hospital, and in Medicine at St. Vincents Hospital, Worcester, Massachusetts. Residencies followed in Medicine and Cardiology at the New England Center Hospital, and in Medicine at the New England Deaconess Hospital.

Among Dr. Page's teaching and hospital appointments have been Research Assistant, and Assistant in Medicine, Tufts College Medical School. At present he is Associate Clinical Professor of Medicine, University of Oregon Medical School. He is now on the active staff of the Good Samaritan Hospital, and the courtesy staff of both the Physicians and Surgeons Hospital and St. Vincents Hospital, in Portland, Oregon.

Dr. Page is active in many medical organizations in addition to the American Society of Internal Medicine, of which he was Secretary-Treasurer and is currently the President. He is a Fellow of the American College of Physicians, and Past President and Secretary-Treasurer of the Oregon Society of Internal Medicine.

Dr. Page's publications include: *Evaluation of Diagnostic Tests for Cancer, Studies on Effusions, Electrocardiographic Changes in Hypothyroidism, Pregnancy* and *Diabetes, Toxicity of Carbutamide,* and others.

## DR. AUSTEN

An **I. Ridgeway Trimble Fund Lecture** will be given on Thursday afternoon, May 4, at the Annual Meeting by **W. Gerald Austen, MD,** on *THE SURGICAL TREATMENT OF ACUTE CARDIOGENIC SHOCK WITH SAPHENOUS VEIN BYPASS.*



**Dr. Austen**

Dr. Austen is President-elect of the Massachusetts Heart Association; Professor of Surgery, Harvard Medical School; Chief, General Surgical Services, and Chief, Surgical Cardiovascular Research Unit, Massachusetts General Hospital; and Senior Research Associate, Massachusetts Institute of Technology.

Dr. Austen, born in Akron, Ohio, received his BS degree from the Massachusetts Institute of Technology and his MD degree in 1955 from the Harvard Medical School. He received his surgical training at the Massachusetts General Hospital. He was appointed Chief, Surgical Cardiovascular Research Unit, Visiting Surgeon, and Chief, General Surgical Services at the Massachusetts General Hospital. He was Senior Registrar in Surgery, Kings College Hospital, London, England; and Honorary Senior Registrar, The Thoracic Unit, The General Infirmary, Leeds, England.

Dr. Austen received the Markle Scholar in Academic Medicine award and the Outstanding Young Men Award, Boston. He is a member of many surgical organizations, and has served many national organizations, either as a member or as Trustee, Vice-President, President, or Chairman.

Dr. Austen is on the Editorial Boards of the Journal of Surgical Research, The American Journal of Surgery, and The Annals of Thoracic Surgery.

## DR. DECKER

On Thursday morning, May 4, at the 174th Annual Meeting **John Laws Decker, MD,** will speak on *CYTOTOXIC THERAPY IN RHEUMATOID ARTHRITIS AND SYSTEMIC LUPUS ERYTHEMATOSUS.* This will be the **Standish McCleary Fund Lecture.**



**Dr. Decker**

Since 1965 Dr. Decker has been Chief, Arthritis and Rheumatism Branch, National Institutes of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Maryland.

A native of Brooklyn, New York, Dr. Decker received his MD degree in 1951 at the College of Physicians and Surgeons, Columbia University. He interned in Medicine at the Presbyterian Hospital, New York, and completed his residency in Medicine at that hospital. He was Research Fellow in Medicine, Harvard University and Massachusetts General Hospital.

Dr. Decker's teaching appointments between 1954 and 1965 included Instructor in Medicine, Columbia University; and Assistant Professor and Associate Professor of Medicine, University of Washington.

Dr. Decker holds many honorary and professional memberships, such as in Phi Gamma Delta, Nu Sigma Nu, Phi Beta Kappa, Alpha Omega Alpha, Omicron Delta Kappa, the AMA and local affiliates, American Rheumatism Association, American Association for the Advancement of Science, Fellow in the American College of Physicians, and others.

Among his awards are: Special Investigatorship, Arthritis and Rheumatism Foundation; and a Travel Grant, 10th International Congress on Rheumatology, Rome, American Rheumatism Association.

Dr. Decker is a member of the Editorial Board of *Arthritis and Rheumatism,* and Editorial Committee of *Manual for Arthritis Clinics,* as well as being on the Medical and Scientific Committee of the Arthritis and Rheumatism Foundation. He was Visiting Professor at Queen's Hospital, Honolulu; and Consultant in Internal Medicine, Madigan General Hospital, U.S. Army, Tacoma, Washington.

## DR. LAWRENCE

**H. Sherwood Lawrence, MD,** will give the annual **George M. Boyer, MD, Lecture** on Friday morning, May 5, during the 174th Annual Meeting of the Faculty. His subject will be *TRANSFER FACTOR THERAPY OF IMMUNO-DEFICIENCY DISEASES.*



**Dr. Lawrence**

A native of New York, Dr. Lawrence received his MD degree at the New York University School of Medicine and is a Diplomate of the American Board of Internal Medicine. He interned, served his residency, and was visiting physician at Bell Medical Center, New York University, New York City. He was consultant physician at the Manhattan VA Hospital and to the Allergy and Immunology Study Section, U.S. Public Health Service Hospital.

At present Dr. Lawrence is Professor and Head of the Infectious Disease and Immunology Division, New York University School of Medicine.

## DR. GOLD

**Martin Irwin Gold, MD,** Professor, Department of Anesthesiology and Head, Division of Respiratory Care, University of Maryland School of Medicine and Hospital, will give a talk on *A FUNCTIONAL RESPIRATORY CARE SERVICE* at the Faculty's Annual Meeting on Thursday afternoon, May 4.



Dr. Gold

Dr. Gold, a native of Philadelphia, Pennsylvania, received his BA degree in 1954 at the State University of New York College of Medicine, Brooklyn. He served a Rotating Internship at the Graduate Hospital of the University of Pennsylvania, and was Resident in Anesthesiology at that hospital.

Dr. Gold's previous appointments include those of Assistant Director, Department of Anesthesiology, U.S. Naval Hospital, Chelsea, Massachusetts; and Visiting Professor, Sabbatical, Department of Medicine, Hammersmith Hospital, London, England.

He is also currently Associate Anesthesiologist at the James Lawrence Kernan Hospital for Crippled Children and Mount Wilson State Tuberculosis Hospital in Baltimore; and Consultant in Anesthesiology at the U.S. Public Health Service Hospital and Baltimore City Hospitals.

Among his numerous professional activities are membership in these organizations: American Society of Anesthesiologists; American Medical Association; American Federation for Clinical Research; American Society of Pharmacology and Experimental Therapeutics; New York Academy of Sciences; Medical Advisory Board of Maryland Blue Shield; Member, Dean's Committee for Reorganization of the Medical Service Plan, University of Maryland School of Medicine; and American Thoracic Society, Eastern Section. He served as Vice-President, President-elect, and President of the Maryland Society of Anesthesiologists.

Dr. Gold is certified by the American Board of Anesthesiology, and is a Fellow of the American College of Anesthesiologists.

**The Maryland State Medical Journal for April will include biographical data and photos on some of the other speakers for the 1972 Annual Meeting.**

# ETHICS CORNER

Recognizing that the practice of medicine is a changing art; and since medicine changes both in the manner in which it is practiced and in the manner in which payments are made for medical services, the Mediation Committee is currently reviewing the Compendium of Decisions . . . Dealing with Ethics, Propriety, and Legality of the Practice of Medicine in Maryland.

Recent changes in policy include the following:

1. It is appropriate for a physician to charge for completion of insurance claim forms, depending on the volume, effort, and time devoted to such activity in his office. It is his prerogative to determine the extent of this service. (MC 2/8/72).

2. It is ethical for a physician to charge interest on accounts that are outstanding because of litigation (eg, automobile and other liability cases, where the physician has agreed to wait on payment of his account until such time as a settlement of the case is reached).

   In cases such as these, the physician must provide an opportunity to the patient or his legal counsel to pay the bill on completion of services rendered the patient, and it should be abundantly clear that payment is expected regardless of the outcome of the litigation.

   In such matters, the physician can accept a promissory note from the patient specifying that interest will be paid in addition to the total bill on account of late payment.

   An alternative to such a procedure would be to obtain a simple statement from the patient that interest will be added and remitted from the proceeds of any settlement. Again, it is important that the patient and his attorney understand that payment is expected regardless of the outcome of the litigation.

* * *

CHICAGO—More babies were born in hospitals in 1970 than in 1969, according to the American Hospital Association. And this is the second straight year that hospitals reported an increase in births. During the years 1962 through 1968 hospital births decreased each year after reaching their all-time high of 3,908,121 in 1961.

The births reported in 1970 totaled 3,537,000. In 1969 hospital births totaled 3,319,315.

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**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

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In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

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| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonikal treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# MARYLAND
## STATE MEDICAL JOURNAL

APRIL 1972

DRUG ABUSE



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MARYLAND GENERAL HOSPITAL
BALTIMORE

# maryland state MEDICAL JOURNAL

VOLUME 21 APRIL 1972 NUMBER 4


**ARTICLES:**


**DRUG ABUSE SECTION** ..... 57-76

**History and Current Account of Med-Chi Role in Drug Abuse in Baltimore and in Maryland** — L. J. Kolodner, MD ..... 57

**The Youthful Drug Abuser: Some Considerations for Treatment** —Maureen McCarthy, PhD ..... 63

**Treatment of Opiate Overdosage** — J. I. Berman, MD ..... 70

**Extent of the Drug Abuse Problem** — Evelyn Goldberg ScD ..... 73

**Drug Abuse News Briefs** ..... 76


**DEPARTMENTS:**


**Your Medical Faculty at Work** — John Sargeant ..... 9

**Woman's Auxiliary—Annual Meeting Plans; Open Letter of Thanks** ..... 16

**Baltimore City Health Department—Transportation for Medicaid Patients** .... 18

**Rehabilitation Medicine—Traction in Cervical Arthritis** — P. F. Richardson, MD 19

**Maryland State Department of Health and Mental Hygiene—Miscellaneous (Also see Page 73)** ..... 30

**Maryland Medical Political Action Committee** ..... 42

**Library—Valued Findings; New Accessions** ..... 45

**Alcoholism Section—Alcoholism Prevalence in Maryland Penitentiary Reception Center** — Steve Hash ..... 80

**Heart Page—Cardial Tamponade and Constrictive Pericarditis Diagnosis—** Ralph Shabeta, MD ..... 91



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ON THE COVER: This month's salute goes to the Maryland General Hospital, 827 Linden Ave., Baltimore.

**MISCELLANY:**


Hospital Salute **5**

Doctors Take Note **6**

Doctors in the News **7**

Medical News Briefs **8**

Director's Newsletter **13**

American Association of Medical Assistants **21**

Component Societies **22, 27**

Annual Meeting Hotel Reservation Forms **30, Cover 3**

Book Reviews **31**

Art & Hobby Exhibit **48**

Semiannual Meeting News **86**

MEDIC **94**

Scientific Exhibits **95**

Annual Meeting Advance Program **96**

Annual Meeting Speakers **100**

Classified Advertising **105**

Advertising Index **106**



# rheumatoid arthritic blowup...

## Tandearil® Geigy

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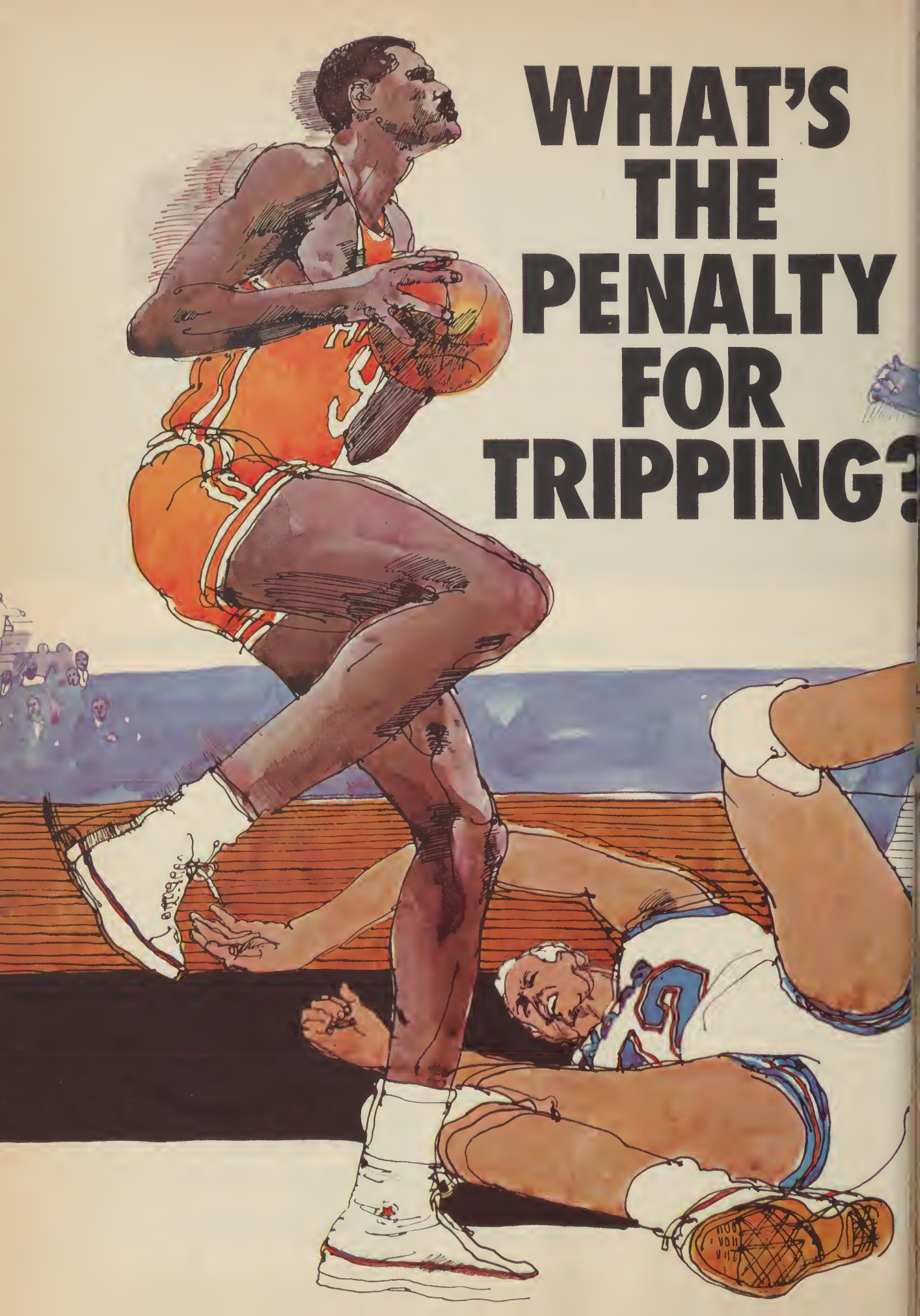
tablets of 100 mg.

*Important Note:* This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. *Indications:* Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis. *Contraindications:* Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy. *Warnings:* Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. *Precautions:* The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia. *Adverse Reactions:* This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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A personal foul against the tripper, and possibly weeks of painful skeletal muscle spasm for the victim.

For the skeletal muscle spasm of leg strains, Valium® (diazepam) can be a valuable adjunct. A dose of 2-10 mg, three or four times a day, goes to work to help break up the cycle of spasm/pain/spasm. The resultant relief of skeletal muscle spasm may permit greater mobilization of the affected muscles and may help the patient resume usual activities sooner than otherwise possible.



*Sudden trauma to and unusual stress on sartorius muscle may cause strain of muscle and tearing of some of the fibers. The resultant muscle spasm can make leg motion painful.*

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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## Med-Chi Salutes

# MARYLAND GENERAL HOSPITAL

Maryland General Hospital has been meeting the health needs of downtown metropolitan Baltimore since it was founded in 1883. An institution which is constantly growing and expanding, the hospital offers a broad range of modern facilities and equipment.

Through the years, MGH has expanded from a capacity of 50 beds to its present complement of 455 beds. Patient accommodations are attractively furnished single, two-bed, or four-bed rooms.

The present facilities are a far cry from a humble beginning in 1883. What is today's new Maryland General began in 1946, when the people of Baltimore contributed funds for a new building program.

The first major unit of seven floors and basement was dedicated in 1956. A nurses' home was completed in 1961, and another major unit in 1962.

The most recent addition—the Eye, Ear, Nose, and Throat Wing—was finished in 1968. It houses the Ophthalmology and Otolaryngology Departments as well as a new Central Service Room, Pharmacy, Pediatric Area, and 13-bed Coronary and Special Care Unit.

This new Coronary Care Unit features the latest in electronic monitoring devices. Developments in kidney research are centered in the new Renal Lab, equipped with an artificial kidney.

Other special areas include the Department of Nuclear Medicine, Surgical Intensive Care Unit, Pulmonary Laboratory, and a complete Research Department.

Maryland General Hospital is a nonsectarian, fully accredited, voluntary teaching hospital affiliated with the University of Maryland. A cooperative agreement between the University and MGH provides clinical experience for many University medical students.

An active intern and residency program is a vital part of the MGH philosophy of providing outstanding patient care through continuous research and education. In addition, MGH operates its own nursing and radiology schools.

Executive Vice-President-Administrator Barry Bowers, and Chief of Staff William R. Lumpkin, MD, head the hospital's administrative-medical groups.

## Precocious Puberty

The cooperation of physicians is requested in the referral of patients with precocious puberty to the National Institute of Child Health and Human Development's Reproduction Research Branch at the Clinical Center.

Patients will be considered for study and treatment regardless of age, sex, or duration of signs.

Interested physicians may write or phone Howard Kilin, MD, or Griff T. Ross, MD, Clinical Center, Room 10-B-09, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-4686.



HOSPITAL DONATION—A $20,000 check, raised by the Women's Auxiliary of South Baltimore General Hospital, was presented to the hospital recently. The check is the third part of a $100,000 pledge. Pictured left to right: Mrs. Karl J. Kalvelage, president of the Auxiliary; Carl Behm, hospital director; Harry B. Cummings, president of the Board of Trustees; and Mrs. Raymond Miller, Jr., first vice president of the Women's Auxiliary and gift shop chairman. At the same time, a special group of 22 was honored for having given 28,500 hours of volunteer work since 1968. Mrs. Miller topped the list with 3,500 hours.

# Doctors take note...

## MARYLAND AREA MEETINGS

Apr 30 – May 7 — **Ten Day Health Plan.** (How to Stop Smoking), Coolfont Recreation, Berkeley Springs W Va. Sponsor: Washington Sanitarium & Hosp. Cost $269. Contact: Ten Day Stop Smoking Office, Wash San & Hosp, 7600 Carroll Ave, Takoma Park Md 20012, tel (301) 589-8800.

May 18-19 — **National Cancer Institute.** Chemotherapy program, Bethesda, Md. Current concepts in trtmt of malignant disease. Crs geared to general physician w/interest in oncology problems. Organized by Drs Carbone, Carter & Gold. Crs aprvd for cr by AGP. Contact: Scientific Director for Chemotherapy, National Cancer Institute, Bethesda Md 20014.

May 20-21 — **Assoc for Advancement of Medical Instrumentation.** AAMI/FDA Natl Conf on Med Device Stds, Washington. Contact: M J Miller, Exec Dir, AAMI, 9650 Rockville Pike, Bethesda Md 20014.

## AMERICAN COLLEGE OF PHYSICIANS

(All contacts ACP, 4200 Pine St., Phila Pa 19104.)

May 8-12 — **Clinical Immunology.** Royal Victoria Hosp, Montreal.

May 15-19 — **Neurology & the Internist.** New York Hosp-Cornell Med Gen, New York NY.

May 22-26 — **Mgt of Common Chronic Med Diseases.** Univ of Kentucky College of Med, Lexington Ky.

May 24-26 — **Progress in Nephrology.** Georgetown Univ, Washington DC.

Jun 5-7 — **Progress in Internal Medicine: Emphasis on Humeral, Metabolic & Immune Mechanisms.** Univ. of Iowa Sch of Med, Iowa City Iowa.

## AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS

May 12-13 — **Kentucky Ob-Gyn Society.** 3d Biennial Symposium, Cancer in Women, Louisville. Contact: C R Potts MD, 750 Medical Towers South, Louisville Ky 40202.

May 12-13 — **American College of Legal Medicine.** Anl Mtg, Miami. Contact: Exec Secy, Amer Col of Legal Med, 1340 N Astor St, Suite 1201, Chicago Ill 60610.

May 26-27 — **8th Anl E C Hamblen Symposium on Reproductive Endocrinology & Family Planning.** Durham N C. Contact: C B Hammond MD, PO Box 3143, Dept of Ob&Gyn, Duke Univ Med Cen, Durham N C 27710.

## MISCELLANEOUS MEETINGS

Apr 29-30 — **Natl Guild of Catholic Psychiatrists.** Dallas. Contact: D J Alamprese MD Pres, St. Agnes Med Cen, Wilkens & Pine Heights Ave, Baltimore Md 21229, tel (301) 646-2270.

May 1-3 — **Natl Hosp Safety Seminar.** Patient Safety & Preventive Med as Applied to Safety, Stouffer's Inn, Indianapolis. Contact: Phil Weiner, Natl Safety Council, 425 N Michigan Ave, Chicago Ill 60611.

May 1-3 — **Natl Paraplegia Foundation.** International Scientific Conf, Fort Lauderdale Fla. Contact: Natl Para Found, 333 N Michigan Ave, Chicago Ill 60601.

May 22-25 — **International Childbirth Educ Assoc.** 7th Biennial Conv, Milwaukee. Contact: ICEA Conv, 11420 W Belmar Dr, Hales Corners Wisc 53130.

Jun 1-3 — **7th Natl Cancer Conf.** Biltmore Hotel, New York City. Sponsors: Amer Cancer Soc & Natl Cancer Inst. No regis fee. Preregistration required. Contact: S L Arje MD, Coord on Natl Conf on Cancer Chemotherapy, c/o Amer Cancer Soc, 219 E 42nd St, New York N Y 10017.

Jun 8-11 — **Cardiac Arrhythmias.** Cavalier Hotel, Virginia Beach Va. Sponsors: Council on Clinical Cardiology, Amer Heart Assoc & Tidewater Heart Assoc. Contact: C L Baird Jr MD, Virginia Commonwealth Univ, Med Col of Va, Hlth Science Cen, Box 894, Richmond Va 23219.

# Doctors in the News



Dr. Wollenweber

Maryland's first medical examiner has been elected president of the Criminal Justice Commission, Baltimore citizens' crime watchdog.

**Henry L. Wollenweber,** MD, a pathologist who was medical examiner from 1939 to 1944, assumes the presidency at a time when the crime commission is facing a serious funding crisis. Previously financed totally by the Community Chest, the commission must raise a substantial amount of new money from other sources to continue its basic program.

The commission is a nonprofit agency sponsored by 27 community organizations to work for more effective crime control in metropolitan Baltimore.

Dr. Wollenweber is medical director of Baltimore's Hemex Center. He received his premed certificate from New York University and his MD from New York Medical College.

He interned at Gorgas Hospital in Panama and served as a commissioned officer in the Public Health Service. After serving as medical examiner for the State of Maryland, he went into private practice in 1944. He served on the faculty of the University of Maryland; is editor of *Office Pathology,* a medical publication; and president of Laboratory Management Service, a scientific research and development organization.

His principal interest is industrial pathology, which he pioneered while serving on the Board of Governors of the College of American Pathologists. Having founded the Section of Pathology of the Baltimore City Medical Society and the Maryland Society of Pathologists, he has served these organizations as officer in many capacities.

•

The medical staff of Sinai Hospital of Baltimore has elected three new officers to one-year terms. They include **Samuel J. Abrams,** MD, president; **David M. Solomon,** MD, vice president; and **George A. Abeshouse,** MD, secretary-treasurer. Dr. Abrams is senior attending physician in surgery; Dr. Solomon is an attending physician in Ob-Gyn; and Dr. Abeshouse is an attending physician in urology.

•

**Eugenia Z. Marchese,** MD, has been named president of the Laurel Medical Society, succeeding **Felix Flores,** MD. A pediatrician, she is a Laurel native who has been practicing there for the past year. She received her MD from Howard University in 1967.

Other new officers include **Louis Tinnin,** MD, vice president; **Bradley King,** MD, treasurer; and **Ahmad Shamim,** MD, secretary.

A former Marylander, **William L. Stewart,** MD, has been appointed professor and first chairman of the Department of Family Practice, Southern Illinois University School of Medicine. A 1951 graduate from The Johns Hopkins School of Medicine, his former position was associate professor of medicine and head of the division of family medicine, Department of Medicine, University of Maryland School of Medicine.

•

Two Maryland doctors have been certified as Fellows of the American College of Anesthesiologists: **Gulen F. Tangoren,** MD, Bethesda; and **Jieh Chyou Yang,** MD, Kensington.

•

**Jules I. Cahan,** MD, announces the removal of his general surgery office to the Forest Glen Medical Center, 9801 Georgia Ave., Silver Spring, Md. 20902.

•

**Paul R. Ziegler,** MD, Ellicott City, was among the participants in the 1972 Symposium on Community Medical Services and the Management and Design of Emergency Departments held in Las Vegas on February 23 and 24. Dr. Ziegler is the senior attending physician at Baltimore's St. Agnes Hospital.

•

Baltimore County Health Officer **Donald J. Roop** has added another set of initials to his MD and MPH. He is now a Fellow (FCPM) of the College of Preventive Medicine.

# Medical News Briefs

## Help Camp Glyndon

Due to the generosity of Camp Glyndon's many friends, the Maryland Diabetes Association reports the vandal-damaged camp will reopen on July 2 with 12 new bunk houses, in addition to the rebuilt six permanent buildings.

The camp will be in full operation for three periods: an initial two-week period, followed by a three-week period, and closing with a two-week period. Each camping session can accommodate 120 children.

They extend an invitation to all physicians and clinics to refer diabetic children from ages five to 15 years. There are no campership fees. The cost to the Maryland Diabetes Association is $135 per week per child. Parents and guardians may contribute towards the cause if they so desire.

Applications and inquiries are welcomed. Contact the Maryland Diabetes Association, 407 Reisterstown Road, Baltimore 21208, or phone (301) 358-2445.

## Clinical Center Studies

The cooperation of physicians is requested in the referral of patients with cancer of the oral cavity, pharynx, larynx, or paranasal sinuses for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, NIH, Bethesda, Md.

Patients selected for admission and treatment will be included in an adjuvant-therapy protocol where the treatment modalities of surgery, irradiation, and chemotherapy will be combined in such a manner as to determine the feasibility of such a therapeutic approach and its potential for decreasing the incidence of local recurrence and metastases.

Interested physicians are asked to contact Alfred S. Ketcham, MD, Clinical Center, Room 10-N-116, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-4164.

Dr. Ketcham also requests similar cooperation in the referral of patients with melanomas and sarcomas of soft tissue and bone.

Needed are patients with primary tumors and those with limited metastases which are amenable to primary surgical treatment. Selected patients will be admitted to combined surgery, chemotherapy, and immunotherapy protocols.

## Reticulum Cell Sarcoma

The cooperation of physicians is requested in the referral of patients with reticulum cell sarcoma for studies being conducted by NIH at Bethesda, Md.

Patients having previously untreated reticulum cell sarcoma are needed to participate in clinical trials. Those in the early stages of disease are being studied in collaboration with the Radiation Branch.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission may write or telephone Phillip Schein, MD, Clinical Center, Room 4-B-13, National Institutes of Health, Bethesda, Md. 20014, phone (301) 496-2031, or Vincent T. DeVita, MD, Clinical Center, Room 12-N-226, NIH, Bethesda, phone (301) 496-4916.

## Healing Physician

Claude A. Frazier, MD, 4-C Doctors Park, Asheville, N. C. 28801 is editing a book on the role of faith or religion in healing from a physician's standpoint.

He requests that any physician interested in contributing to this book write to him at this address.

## Rheumatology Certification

The American Rheumatism Association Section of The Arthritis Foundation is offering a review session in rheumatology mainly for physicians wishing to take the subspecialty exams for certification in rheumatology being given for the first time this year by the American Board of Internal Medicine on October 17.

The review session will be held June 10 at the Fairmont Hotel in Dallas in conjunction with the annual meeting of the American Rheumatism Association.

Registration fee is $50. For information and reservations contact Executive Secretary, American Rheumatism Association Section, The Arthritis Foundation, 1212 Avenue of the Americas, New York, N.Y. 10036 no later than May 25.

# your medical faculty at work

**by John Sargeant,**
**Executive Director**

**The Executive Comittee met on Thursday, February 10, 1972, and took the following actions:**

1. Adopted amendments to the Nurses Protocol as recommended by the Nurse Liaison Subcommittee.

2. Selected Margaret Sherrard, MD, Towson, as Faculty representative on the Maryland State School Health Council.

3. Referred to the Council the following policy recommendation:

   That the Faculty is willing to accept a limitation on fee increases only if it applies to all professional groups, as well as those of physicians, dentists, and those in the health fields.

4. Determined that a special mailing to all members advising them of the necessity of posting a sign indicating fees are available for examination on request of a patient was unnecessary. An item to this effect is scheduled to appear in an early issue of THE JOURNAL; the American Medical News has a complete report on this; and a suggested sign will appear in an early issue of JAMA.

5. Declined to participate in a meeting suggested by the Comprehensive Health Planning Agency with respect to hospital privileges for podiatrists. It did so on the basis that Faculty policy is adequately clear in this regard. The House of Delegates in April 1970 adopted a policy that would comply with the same standards as the Joint Commission on Accreditation of Hospitals. Currently this is essentially that such privileges may be granted subject to determination as to the credentials of the podiatrist and based on a local medical staff decision.

6. Agreed that it was unnecessary, at this time, to discuss licensure of ambulatory care facilities, such as inhalation therapy installations, etc.

7. Received a letter from the Maryland Blue Cross Board indicating that Faculty representation on the Board is no longer provided for in the Blue Cross Bylaws. The new Board will consist of 27 members, of whom not more than nine would be providers of health care services or affiliated with health care institutions.

8. Submitted the following names for possible appointment by the Governor for the group indicated:

   Advisory Council on Hospital Construction: Benedict Skitarelic, MD, Cumberland
   Advisory Board on Hospital Licensing: John Kehoe, MD, Riverdale
   Board of Physical Therapy Examiners: Richard W. Ferguson, MD, Baltimore
   Commission on Medical Discipline: John M. Dennis, MD, Baltimore

9. Heard that some of the material given the Smithsonian Institute on indefinite loan would highlight an exhibit on the History of Medicine, scheduled to open around March 1.



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**IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media. Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.**

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**Precautions:** Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, somnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarity to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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# executive director's newsletter

April 1972

CAUSE FOR CONCERN?

THERE ARE PEOPLE AROUND PLANNING the future of the medical profession. This recommendation has been sent to the Arizona Legislature: "The Arizona Health Planning Authority should be assigned responsibility for determining, with appropriate organizations representing the principal practitioners of the healing arts, how the scope of health services performed by the various professions licensed in Arizona can be extended to make better use of existing personnel for providing health services." Complete program of AHPA was sent to Arizona Medical Assn members with admonition: "Gentlemen, read it carefully. It is your future they are planning. Be sure your thoughts are expressed to your state legislators, as they will soon be asked to pass enabling legislation."

IF THERE WERE NO AMA.....

Who would accredit the various residency and other training programs throughout the country?

Who would represent the physician in the U.S. Congress with respect to Food and Drug Regulations, and Federal Legislation regarding the way and where medicine is practiced?

Who would establish the various ethical problems involving medicine?

Who would represent the physician on the Joint Commission on Accreditation of Hospitals and other such national bodies?

Who would have established the Specialty Boards we now all take for granted?

Who would counsel and advise the various federal regulatory agencies regarding the physician's difficulties and problems?

From whom would advice be sought with respect to legal and ethical problems involving the practice of medicine?

SMITHSONIAN EXHIBIT

A portion of the medical artifacts and memorabilia placed on indefinite loan with the Museum of History and Technology at the Smithsonian Institute is now on display there.

It is located on the 1st floor near the Pendulum area. Appropriate recognition has been given to the Faculty.

NO REFERENCE COMMITTEE MEETING

The deadline of Wednesday, March 8, 1972 having passed with the receipt of no resolutions for consideration of the annual session of the House of Delegates, there will be no need for a meeting of the Reference Committee.

Resolutions may now only be introduced through committees of the Faculty or the Council.

CONTRIBUTIONS TO POLITICAL CAMPAIGNS

Starting with calendar year 1972 Income Tax Returns, an individual, other than a non-resident alien, will be allowed to designate $1.00 of his Income Tax Liability ($2.00 for married persons filing joint returns) to be set aside in a special account to be used by Presidential candidates and their political committees in national elections. In addition, a taxpayer may now deduct up to $50.00 as an itemized deduction for contributions to a political campaign. The limit increases to $100.00 on a joint return. Or, in lieu of an itemized deduction, a taxpayer individual may claim an income tax credit of $12.50 (Joint return--$25.00) for political contributions. The deduction and credit allowed will apply to tax years ending after December 31, 1971 and for contributions paid after the date of the enactment of the law.

ANNUAL MEETING

Annual Meeting dates are May 3, 4, and 5, 1972. If you do not have these already noted on your calendar, please do so.

John Sargeant

Executive Director

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# AUXILIARY PLANS FOR 23rd ANNUAL MEETING

The 23rd annual meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty will be held at the Baltimore Hilton Hotel on May third and fourth.

Guest of honor will be Mrs. Howard Liljestrand of Honolulu, Hawaii, a director of the Woman's Auxiliary to the American Medical Association as well as the national chairman of the International Health Activities committee. The wife of Howard Liljestrand, MD, a specialist in industrial medicine, Mrs. Liljestrand has been active in national auxiliary work since 1962, serving many chairmanships, as well as holding the offices of constitutional secretary, treasurer, and first vice president.

She holds a BA in premedical sciences and an MA in cytology, in addition to having completed four summers of study and research at biological laboratories. She was an instructor at Barnard College, Columbia University; set up secretarial departments for pathology and roentgenology at Queen's Hospital in Honolulu; and was business manager and administrative assistant at Leeward Hospital and Clinic, Aiea, Hawaii.

The mother of four children, Mrs. Liljestrand has been active in many civic affairs: girl scouts, Planned Parenthood, PTA, Central Union Church, Honolulu Academy of Arts, Uluniu Women's Swim Club, the Hawaii Heart Association, and the Hawaii Geographic Society.

Not only will Mrs. Liljestrand install the new state auxiliary officers on Thursday, May fourth at the morning meeting of the Auxiliary, but she will be the guest speaker following the afternoon luncheon, choosing as her subject, "The Encroaching Jungle."

The keynote speaker will be Z. John LeVay, MD, psychiatrist and professor of psychology, Catonsville Community College. A well-known speaker, Doctor LeVay will talk on "Man, Woman and Person."



**Mrs. Howard Liljestrand**

Under the chairmanship of Mrs. Bernard S. Gordon, an Art and Hobby Exhibit will be held from May second until May fifth at the Civic Center, where the Med-Chi convention will be taking place.

All doctors' wives are invited to attend the annual meeting and luncheon.

Mrs. Walter M. Hammett is convention chairman. Her co-chairman is Mrs. David C. Donovan. Other members of the convention committee are Mrs. Arlie R. Mansberger, tickets and reservations; Mrs. Charles H. Williams, regis-

tration; Mrs. James L. Garey, hospitality; Mrs. Albert Cooper, flowers and decorations; Mrs. Andre Fesus, publicity; Mrs. Martin E. Strobel, credentials; Mrs. Roy Skipton, necrology; and Mrs. Raymond M. Yow, past presidents' luncheon.

Mrs. Robert Reiter, president, will preside over the preconvention Board meeting on Wednesday as well as the general session on Thursday. Mrs. Marvin L. Kolkin, who will be installed to succeed Mrs. Reiter, will preside over the post convention Board meeting on Thursday afternoon.

On the program will be greetings from the Medical and Chirurgical Faculty by Paul A. Mullan, MD, chairman of the Public Relations Committee, and advisor to the Auxiliary; a memorial service for deceased members conducted by Mrs. Roy Skipton; special reports by Mrs. Michael Dodd, president of the Woman's Auxiliary to the Student AMA, University of Maryland chapter; and Miss Daniele Shipley, president of the Health Careers Clubs of Maryland. Reverend Herbert P. Clough, pastor of Brantly Baptist Church, will offer the invocation at the luncheon. John F. Schaefer, MD, president of the Medical and Chirurgical Faculty, is expected to bring greetings to the Auxiliary.

Many out-of-state guests are expected to attend the meeting and luncheon. Their hostesses will be Mesdames Otto C. Brantigan, Jesse C. Coggins, Elliott C. Flick, Philip W. Heuman, Fred E. Kadan, Charles B. Marek, Wallace H. Sadowsky, William S. Stone, John Robinson, H. Leonard Warres, and Raymond M. Yow.

# AN OPEN LETTER OF THANKS

Dear Faculty Members,

On behalf of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, and as State Chairman AMA-ERF, I extend sincere and grateful thanks to each one of you who has so generously contributed to our cause.....AMA-ERF.

As you know, your AMA-ERF monies designated for particular medical schools provide those schools with the flexible funds necessary to pursue their many activities; help to keep various educational programs current and stimulating; and often serve to aid in the procurement of new and more modern equipment....a marked contrast to the support they receive from endowment programs, government and state sources which is ear-marked for specific purposes and is received a year after the initial request.

Your undesignated funds are equally divided among the 103 certified United States and Commonweath medical schools.

Contributions which you have designated for the Student Loan Program help to alleviate the financial difficulties of medical students, interns and residents, and serve to encourage career decisions in favor of Medicine. Each $1.00 contributed to the Student Loan Fund releases $12.50 in working capital. An upsurge in loans occurred during the first half of 1971 reflecting the increase in medical school enrollments and the rising need among many medical students for funds.

Our National Auxiliary has set a goal of $900,000 in AMA-ERF funds for 1972. With the continued faithful support of you, the Faculty Members, and the diligent efforts of each Auxiliary member, Maryland will have a record of which we can be proud.

In deepest appreciation...yours for AMA-ERF,

/s/ MRS. ELMER G. LINHARDT
State Chairman, AMA-ERF

ROBERT E. FARBER, MD, MPH, COMMISSIONER

**Baltimore City health department**

# TRANSPORTATION FOR MEDICAID PATIENTS

The City Health Department's Bureau of Special Home Services has expanded its transportation services to include all Baltimore City residents who hold a current State medical assistance card regardless of age. Any resident who has a Medicaid card with a serial number beginning with 30 and who needs transportation to a doctor or a clinic may obtain a ride by calling 752-2000, ext. 2856, weekdays between 8:30 AM and 4:30 PM.

Escort service at the hospital will also be provided, but only for those patients over 60 years of age. Patients under age 60 must make their own arrangements if they wish to be escorted; very young children must be accompanied by an adult.

The transportation of the elderly poor to medical facilities was provided from 1965 to 1967 by the Baltimore City Community Action Agency. During this period, transportation of those over 60 was accomplished by taxi or by Baltimore Transit Company buses with the federally-funded agency paying the fare. In 1967, the CAA program was delegated to the Baltimore City Health Department as the Bureau of Special Home Services. The transportation of the aged chronically ill was improved by the addition of three minibuses. All costs for this program were borne by the City Health Department. In May 1971, an agreement with the Maryland State Department of Health and Mental Hygiene released $44,000 in Medicaid funds for patient transportation. It is this money which allows the city to expand its patient transportation facilities by three additional minibuses and to permit more patients to obtain the much needed transportation to medical facilities.

In addition to the transportation services, the Bureau of Special Home Services assists chronically ill elderly persons to obtain the medical, social, and community services they need and for which they are eligible. Since it became a City Health Department bureau in 1967, more than 6,000 Baltimore City residents of low income have benefited from its services.

Physicians desiring additional information on the work of the Bureau of Special Home Services may call Miss Adele Wilzack, RN, Acting Director, tel. 752-2000, ext. 2856.


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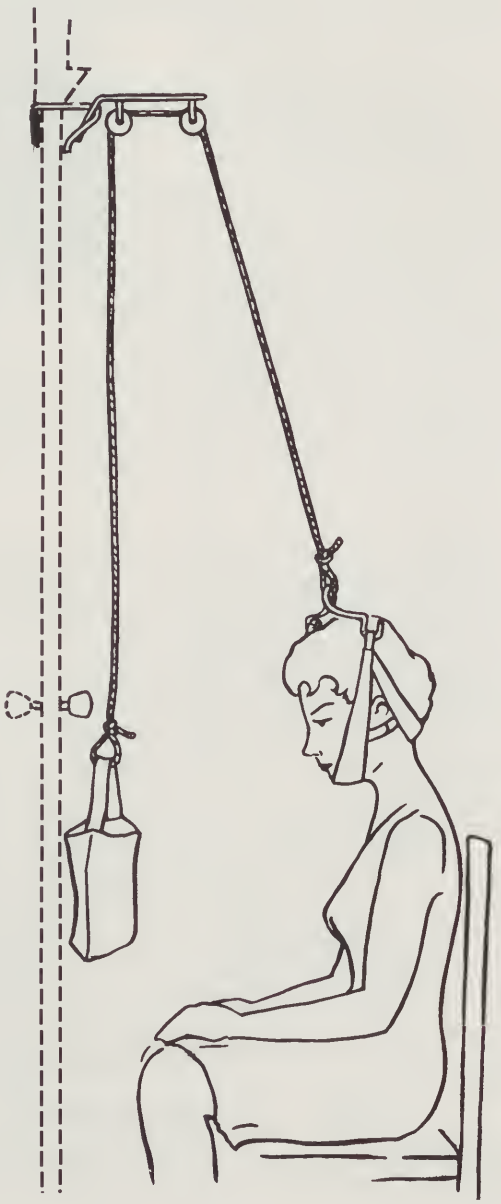
*John Galsworthy*

**FREDERICK J. BALSAM, MD, EDITOR**

rehabilitation medicine

# TRACTION IN CERVICAL ARTHRITIS

**PAUL F. RICHARDSON, MD**
**Professor and Head**
**Department of Rehabilitation Medicine**
**University of Maryland School of Medicine**
**Baltimore**



A common problem associated with cervical arthritis (spondylosis) is nerve root compression, often manifested in its early stages by sensory disturbances in the upper extremities. The purpose of this paper is to describe a usually effective, yet inexpensive, method of treating these radicular symptoms. No attempt will be made to discuss differential diagnosis of lesions of the cervical spine, although proper diagnosis is essential.

Degenerative arthritis of the cervical spine is a common X-ray finding in the middle and later years of life. It may or may not be associated with radicular symptoms of numbness and tingling, and sometimes pain in the upper extremities — usually the hands. Conversely, some individuals may have these complaints without significant X-ray evidence of spur formation or intervertebral foraminal encroachment. It is likely that beginning irritation of the sensory nerve roots may take place prior to sufficient calcification for X-ray visibility.

Symptomatology is related to the specific nerve roots involved and may include several segments. Symptoms are usually unilateral but may be bilateral, although not necessarily symmetrical. Associated occipital headache may be due to irritation of the upper cervical roots, since this symptom is often relieved by traction. On occasion, when one is in doubt as to whether the upper extremity symptoms are due to nerve root irritation, traction can be used as a therapeutic trial.

Treatment outlined here is primarily directed toward the chronic symptoms which are usually of insidious beginning. In acute onset of symptoms associated with trauma, a soft cervical collar may be used to restrict neck movement on a temporary basis, since this is often helpful in relieving pain and muscle spasm. In the radiculopathy due to nerve root irritation from osteophyte encroachment, cervical collars usually are of little help and may be contraindicated since the long-term use of a collar tends to increase muscle stiffness by restricting motion. Adequate cervical traction is usually effective in relieving the radicular symptoms without use of a collar. The relief of the symptoms caused by nerve root irritation is primarily effected through the use of cervical traction of sufficient magnitude, duration, and frequency to relieve root pressure.

In order to facilitate the effectiveness of the traction, analgesics and muscle relaxants should be given on a 24-hour basis during the early phase of treatment. As symptoms are relieved, analgesics can be discontinued, and usually muscle relaxants as well. Traction, which can be constant or intermittent, should be preceded or accompanied by the application (15 to 20 minutes) of local heat to the cervical musculature, which aids in analgesia and muscle relaxation. Moist heat is preferred by most patients, but generally dry heat from an electric heating pad is more convenient and probably just as effective.

Although cervical traction has been used for many years in the treatment of radiculopathy associated with cervical spondylosis, its effectiveness has been quite variable because of poor technique. Most of the poor results are due to improper instruction of the patient in the use of the traction, insufficient tractive force, improper direction of pull, and infrequent treatment sessions. The preferred method of beginning treatment is to use a period of traction of 15 to 20 minutes' duration at least twice a day. A home traction apparatus is available using a bracket that fits over the top of a door for the suspension of a rope with a weight on one end and a halter with spreader bar on the other. The halter fits over the patient's head so that the tractive force is exerted on the occiput and the chin with the patient in a seated position (see illustration).

Care should be taken that the tractive force pulls the patient's head slightly in flexion, and for this reason the patient must sit facing the door. With the patient's back to the door, the suspending arm of the traction apparatus is so short that it pulls the cervical spine into extension which is contraindicated. Although the traction should be maintained about 15 to 20 minutes, it need not be continuous, but may be interrupted from time to time if it becomes tiring. The patient can do this by lifting the weight for a minute or so and moving his head about. Beginning with a weight of 15 pounds, daily increments of two to three pounds are added up to a total of 25 to 35 pounds or more, or until symptoms are relieved.

At that point traction is reduced to once daily for a period of ten days to two weeks, and then reduced to three times a week for another two-week period. Then if the patient remains asymptomatic, he is instructed to do the traction once or twice a week over the next two months. Treatment can then usually be discontinued, although the patient should be informed that symptoms may return, and if this occurs he should resume the traction until asymptomatic. Some patients must remain on a maintenance schedule of once or twice a week in order to prevent recurrence of the symptoms.

A word of caution: some manufacturers of home traction apparatus for use over a door include a picture of the apparatus showing a patient sitting with back toward the door. Such a position will cause the neck to be pulled in extension and will defeat the purpose of the traction. Proper instruction in the use of the traction cannot be overemphasized; if this is not done personally by the physician, he should refer the patient to a physical therapist for this purpose. The apparatus is relatively inexpensive, costing in the range of $10 to $12.

Additional helpful hints in the management of this condition include having the patient sleep on a firm mattress with adequate thickness of pillow to keep the cervical spine in nearly straight alignment, especially when side lying. These individuals should also be advised that their automobiles should be equipped with headrests adjusted to the proper height because they are very susceptible to cervical trauma from rear end collisions. Patients with radiculopathy due to cervical spondylosis should be followed for evidence of myelopathy or cervical motor root involvement, both of which are indications for neurosurgical consultation and possible intervention.

A simple, inexpensive home program for the treatment of the sensory symptoms of cervical nerve root irritation has been described. If properly executed and supervised, this method will often reduce the need for medication and/or an unsightly and restrictive collar, as well as delay or prevent the need for more radical treatment.

# American Association of Medical Assistants

Russell S. Fisher, MD, chief medical examiner of the State of Maryland, is currently, conducting a course in Medical Law and Economics for the members of the Baltimore Association of Medical Assistants. The courses are being given on Tuesday evening at 6 PM, with a general attendance of well over 40 persons. The course work given by Dr. Fisher follows the Study Outline from AAMA for the Certification Examination. Subjects being discussed include the following:



**Dr. Fisher**

MEDICAL PRACTICE REQUIREMENTS
- Licensure, prerequisites
- Licensing
- Grounds for revocation or suspension of license

LEGAL RELATIONSHIP OF PHYSICIAN & PATIENT
- Creation of a contract
- Termination of a contract
- Breach of contract

PROFESSIONAL LIABILITY
- Malpractice
- Tort liability
- Professional Liability Insurance

PHYSICIAN'S PUBLIC DUTIES & LIABILITIES
- Reports & Services
- Physician as a Witness

TYPES OF MEDICAL PRACTICE
- Individual private practice
- Partnerships
- Employer-employee
- Group Practice
- Industrial or Salaried

TYPES OF MEDICAL CARE
- General practitioner & specialist
- Comprehensive care
- Hospital progressive care

BASIS FOR DETERMINING FEES
- Prevailing rates in the community
- "usual & customary" basis
- Insurance allowance; fee schedules
- Relative value scales

HEALTH & ACCIDENT INSURANCE PROGRAMS
- Group
- Personal
- Workmen's Compensation

GOVERNMENT MEDICAL CARE PROGRAMS
- Social Security Act Programs
- Public Assistance
- Servicemen's Dependents & Veterans
- Regional Health Centers
- Community Mental Health Centers

Several nonmembers of the Association and several lawyers in the community are attending this very interesting and educational course. Law is the system by which we give order to our lives. You should have a broad working knowledge of the manner in which the law affects the practice of medicine and you as a medical assistant. You should also have a general knowledge of the economics of medicine, ie, the demands made for medical service and the various systems through which service is provided.





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**FRANCIS X. CARMODY, MD**
**Journal Representative**

# Baltimore City Medical Society

The regular monthly meeting of the Board of Directors convened on Tuesday, February 8 at 4:30 PM. The minutes of the January 11 meeting were approved as written.

The Board voted to submit the name of Helen B. Taussig, MD, as the Society's nominee for the 1972 Dr. Rodman E. Sheen and Thomas G. Sheen Award. This award is given yearly to an American physician in recognition of outstanding contributions to medicine and consists of a $10,000 cash prize and commemorative plaque. The award is the result of a bequest made in the will of the late Thomas G. Sheen, an Atlantic City businessman, in honor of his brother, the late Dr. Rodman E. Sheen. Selection is made by a special committee of the AMA and the Guarantee Bank and Trust Company of Atlantic City.

Plans for the semiannual meeting, to be held on April 6, were discussed. It was agreed that a program will be presented rather than holding only a business session. The program will concern itself with the regulations regarding hospital utilization set down under the Medicare program. It will include a discussion of the law and the interpretations rendered by fiscal intermediaries. A recent court finding holding a physician responsible for a patient's hospital bill when coverage was denied under an insurance program makes this an important topic of discussion.

Drs. George Entwisle and Elijah Saunders presented an outline of a program for the detection and treatment of hypertension which they are conducting under a federal grant. This program will require that selected patients be treated for hypertension for a period of five years. The Board was assured that the program was being conducted in such a way as to be compatible with private practitioners in the area and provide safeguards for the patients. The patients are carefully informed that only hypertension is treated in the program, and the approval of the family doctor is received before a patient is enrolled. The patient is also informed of what the objectives of the program are and must sign a consent form. Reports obtained from the screening of patients are sent to the attending physician.

A suggestion that a symposium on group practice be sponsored by the Society was referred to the Medical Care Committee for consideration.

The Board voted to request the Medical and Chirurgical Faculty House of Delegates to elect the following members of the Society to Emeritus Membership: Drs. Jacob M. Miller, Helen B. Taussig, and Emmanuel A. Schimunek. All of these physicians have retired from practice.

The treasurer presented a report of the income and expenses incurred thus far this year, which was accepted as an item of information by the Board. The Finance Committee plans to meet with representatives of several city banks in order to learn what investment advice is available to the Society from this source.

A letter from the Regional Planning Council requesting the Society's opinion on the expansion of North Charles General Hospital was discussed. It was pointed out that the RPC has refused to allow Good Samaritan Hospital to open 70 beds for use in the community. In light of this, it was agreed to inform the RPC that the Society has some reservations as to whether this bed space was needed in the community and that action would be withheld until further information was received.

The Board voted to accept the recommendation of the Finance Committee with regard to additional office staff and equipment for the Society.

A letter from Senator J. Glenn Beall, Jr. informed the Board that the National Health Service Corps has not assigned personnel to the Homestead/Montebello area because of problems which have arisen within the community organizations involved. The Society has sponsored this project for some time and it is hoped that the problems will be resolved in the near future so that personnel can be assigned.

The AMA will conduct a Public Affairs Survey for the Society from March 20 to March 23, 1972. This will be to evaluate the Society's effect in the community and to make recommendations for improving the Society's service to its members and the public.




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| phenobarbital (warning: may be habit forming) | (¼ gr.) 16.2 mg. | (½ gr.) 32.4 mg. | (¾ gr.) 48.6 mg. |

**Brief summary.** Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

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Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

**Dosage:**

*For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.*

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"The trouble with people is that they think as long as drugs aren't in their own neighborhood — as long as they think it's only a problem of the ghettoes — they have nothing to worry about. But soon they find out they have a drug problem right in their own area, or even in their own family. If society wants to solve the drug problem they have to stop it no matter where it exists and not take the attitude that as long as it isn't affecting me or my own family I won't worry about it, because eventually it will."

The guest who spoke to the Frederick County Medical Society at its February dinner meeting knew his subject well. He is an inmate, a former drug addict, presently serving time in a state prison for armed robbery to obtain funds to support his addiction.

The program was arranged by the president, Robert J. Thomas, MD, and the guests were introduced by Sgt. Carl Harbaugh of the Maryland State Police. Sgt. Harbaugh has been chief investigator of drug violations in Frederick County; beyond this responsibility, he has worked with members of the Breathedsville Junior Chamber of Commerce in the Breathedsville State Prison to reach groups interested in hearing the message from people who can tell it "as it really is." He had brought two guests to the meeting, the one previously mentioned, and another former addict who is serving time for second-degree murder.

In answer to questions posed by the members, one young man stated he had started on drugs when he was about 14 years old, "because it was the thing to do — to be on the in with the crowd." He added: "Perhaps if I could have been closer to my parents — if they had been interested in me — I might not have gotten involved."

How much did it cost to support his habit? One of the guests said, "about $300 a day." He explained how he would share drugs with a friend in order to get him hooked. Once this was accomplished he would use his friend's money to purchase more drugs for the two of them. When the money ran out he would seek another "friend" to get hooked and repeat the same process. When a friend could not be found then robbery was the next means of obtaining funds.

On the subject of "pot" the question was asked whether either of the guests would want a surgeon to operate on him if he knew the surgeon had just finished smoking pot. The answer: "It all depends on how successful he had been with his previous operations, that's all I would care about." Both guests expressed concern about confining young people convicted of possessing pot with hardened addicts. "They learn too much from the hardened criminal. There should be separate facilities where they can receive good counseling and psychiatric help." Although the guests did not express too much alarm about the use of pot, one did say he would discourage his son from using it, "because it might lead to worse things."

The discussion was of such interest to the group that the formal business session was postponed until next month.

Sgt. Harbaugh informed the group that such programs were available to interested groups; however, it required at least 30 days to process the papers for temporary release of the inmates, so any interested groups should notify him well in advance of any planned program.

ERNEST A. DETTBARN, MD
Journal Representative

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# In acute gonorrhea

## (urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



**Sterile Trobicin®**
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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**Warnings:** Antibiotics used to treat gonorrhea may mask delay the symptoms of incubating syphilis. Patients should carefully examined and monthly serological follow-up for least 3 months should be instituted if the diagnosis of syphilis suspected.

*Safety for use in infants, children and pregnant women has r been established.*

**Precautions:** The usual precautions should be observed w atopic individuals. Clinical effectiveness should be monitored detect evidence of development of resistance of *N. gonorrhoe*

**Adverse reactions:** The following reactions were observ during the single-dose clinical trials: soreness at the injection si urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in norn human volunteers, the following were noted: a decrease in hem

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**High cure rate:* 96% of 571 males, 95% of 294 females**
Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

**Assurance of a single-dose, physician-controlled treatment schedule**

**No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed**

**Active against most strains of Neisseria gonorrhoeae in vitro** (M.I.C. 7.5-20 mcg/ml)

**A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-8

globin; hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25°C and use within 24 hours after reconstitution with diluent.
*Male*—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
*Female*—single 4 gram dose (10 ml) intramuscularly.

**How supplied:** *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
*Susceptibility Powder*—for testing *in vitro* susceptibility of *N. gonorrhoeae*.
**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
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NEIL SOLOMON, MD, PhD, SECRETARY

# Maryland State department of health and mental hygiene

## European Travel Rules Eased

Marylanders planning European trips no longer need immunizations, according to the State's Division of Communicable Diseases.

HEW advises that all European countries have now joined the USA in removing all immunization requirements for persons traveling between the United States and that continent.

The last European countries to require smallpox certificates from American travelers—Spain, Bulgaria, and Russia—dropped their requirements earlier this year. Nor do European countries require cholera or yellow fever shots of travelers from the States, it is reported.

However this relaxation does not affect requirements for certificates for travel in parts of Southeast Asia and South America.

## Maryland Gets Developmental Funds

Maryland has received a federal award of $300,000 to be granted to projects providing supplemental services to the mentally retarded, cerebral palsied, and epileptic.

Grant requests will be reviewed by the State Planning Advisory Council for Developmental Disabilities Services and Facilities.

The grants will go to a select number of agencies offering services that will assist the severely disabled to adjust to effective participation in society, Francis J. Derivan, executive director of the Council, reports. Requests should be forwarded to his attention at 301 West Preston Street, Baltimore 21201.

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**MEDICAL INTERVIEWING, A Programmed Manual, second edition, by Robert E. Froelich, MD, and F. Marian Bishop, MSPH, The C. V. Mosby Company, St. Louis, 1972.**

In this manual, the individual is requested to respond to questions or simulated situations and then to compare such responses with those provided by the authors. It exhibits a useful technique of learning for the student, for practice on the part of those planning to take examinations or tests, or just to keep current with medical knowledge.

**INTRODUCTION TO HEMATOLOGY, by William D. Dougherty, BS, The C.V. Mosby Company, St. Louis, 1971.**

The prime objective of this book, according to the author, is to provide an **introduction** to hematology. It therefore omits all the minute detail about the subject contained in books directed toward the specialist in this area. In short, the book has been written to **understand** not simply **memorize** the whys in hematology. It does this well.

**THE PEDIATRIC NURSE PRACTITIONER, by Fernando J. deCastro, MD, and Ursula T. Rolfe, MD, The C.V. Mosby Company, St. Louis, 1972.**

This manual is intended as an outline to allow nurses to expand their empirical knowledge of ambulatory pediatrics by an orderly exposure to its different aspects. It is also intended as a guide which recent pediatric nurse practitioner graduates can consult while gaining experience and confidence in ambulatory pediatrics during the resolution of their reorientation from a dependent nurse's role to a more independent member of a team delivering health care to children. While this publication would not be of interest to many, it should prove valuable to pediatricians and family physicians who use or intend to use nurses to assist them in their practice beyond what is normally provided by such assistants.

**DRUGS OF CHOICE 1972-1973, by Walter Modell, MD, The C.V. Mosby Company, St. Louis, 1972.**

This book, edited by Dr. Modell, consists of contributions by an impressive list of names. It is a practical guide to the selection of the best drug for a particular therapeutic problem. With the continuing hue and cry by proponents of the use of generic drugs over brand-name or nonbrand-name drugs, physicians should well consider the question of which drug provides the best therapeutics for his patient. There is almost nowhere the physician can turn for the kind of help that he needs — certainly no place where unbiased, authoritative, and definitive information bearing on this problem is brought together and made easily available. This book does just that. It is highly recommended for all physicians to have for easy reference.

**COMPREHENSIVE MANAGEMENT OF EPILEPSY IN INFANCY, CHILDHOOD, AND ADOLESCENCE, by Samuel Livingston, MD, Charles C. Thomas, publishers, Springfield, Ill., 1972.**

This book, by a prominent physician at the Johns Hopkins Medical Institutions, contains contributions by Dietrich Blumer, MD, and A. Earl Walker, MD, also of the Johns Hopkins Medical Institutions. This book is unique in that — in addition to a detailed presentation relative to the socioeconomic, emotional, and legal aspects of epilepsy — there are also comprehensive sections dealing with the medical aspects of this disorder, including a discussion of the therapeutic agents and regimens currently available for the treatment of epilepsy. Its defined purpose is to 1) acquaint the practicing physician with the various therapeutic regimens currently available for the control of epileptic seizures, and 2) to supply the physician with information which he can utilize in his management of the "whole patient." It does this extremely well.

**CARDIOVASCULAR PHYSIOLOGY, by Robert M. Berne, MD, and Matthew N. Levy, MD, The C.V. Mosby Company, St. Louis, 1972.**

This book is designed primarily for medical students, as well as for graduate students. Its fundamental purpose is to emphasize the general concepts and to ignore isolated facts. This is one of a set of companion books on human physiology, so that some of the material one might ordinarily expect to be covered in it will be covered in other texts of the series. This publication has been updated and made current by the authors as it is the second edition.

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**CAUTION:** Federal law prohibits dispensing without prescription.

**Indications:** Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

**Contraindications:** Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

**Warnings:** When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

**Drug Dependence:** Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

**Usage In Pregnancy:** The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

**Usage In Children:** Not recommended for use in children under 12 years of age.

**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

**Adverse Reactions: Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

**Dosage and Administration:** The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

**Overdosage: Manifestations:** Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

**Management:** Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

**How Supplied:** Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

**Full information available on request.**

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**Pre-Sate®** (chlorphentermine HCl)...the increasingly practical appetite suppressant



# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

fections caused by susceptible strains
f pneumococci, streptococci, and
aphylococci, including penicillin-
sistant strains. Staphylococcal strains
sistant to Lincocin (lincomycin
ydrochloride, Upjohn) have been
covered. Before initiating therapy,
ulture and susceptibility studies should
e performed. Lincocin has proved
aluable in treating patients hyper-
nsitive to penicillin or cephalosporins,
nce Lincocin does not share
ntigenicity with these compounds.
owever, hypersensitivity reactions
ave been reported, some of these in
atients known to be sensitive to
enicillin.

**Well tolerated at infusion site:** Lincocin
travenous infusions have not
roduced local irritation or phlebitis,
hen given as recommended. Lincocin
usually well tolerated in patients who
e hypersensitive to other drugs.
evertheless, Lincocin should be used
autiously in patients with asthma or
gnificant allergies.

n patients with impaired renal function,
ie recommended dose of Lincocin
ould be reduced to 25—30% of
ie dose for patients with normal
dney function. Its safety in
egnant patients and in infants
ss than one month of age has
t been established.

**incocin may be used with other
ntimicrobial agents:** Since Lincocin
stable over a wide pH range, it is
itable for incorporation in
travenous infusions; it also may be
administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.




1972 The Upjohn Company



Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonikal treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatme
*Skin and mucous membranes*—Skin rash urticaria, vaginitis, and rare instances of e foliative and vesiculobullous dermatitis ha been reported. *Liver*—Although no direct lationship to liver dysfunction is establishe jaundice and abnormal liver function te (particularly serum transaminase) have be observed in a few instances. *Cardiovascu* —Instances of hypotension following pare teral administration have been reporte particularly after too rapid IV administ tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more admi istered IV, dilute in 500 ml of fluid a administer no faster than 100 ml per ho *Special senses*—Tinnitus and vertigo ha been reported occasionally. *Local reactio* —Excellent local tolerance demonstrated intramuscularly administered Lincoc (lincomycin hydrochloride). Reports of p following injection have been infreque Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distill water or normal saline has produced local irritation or phlebitis.

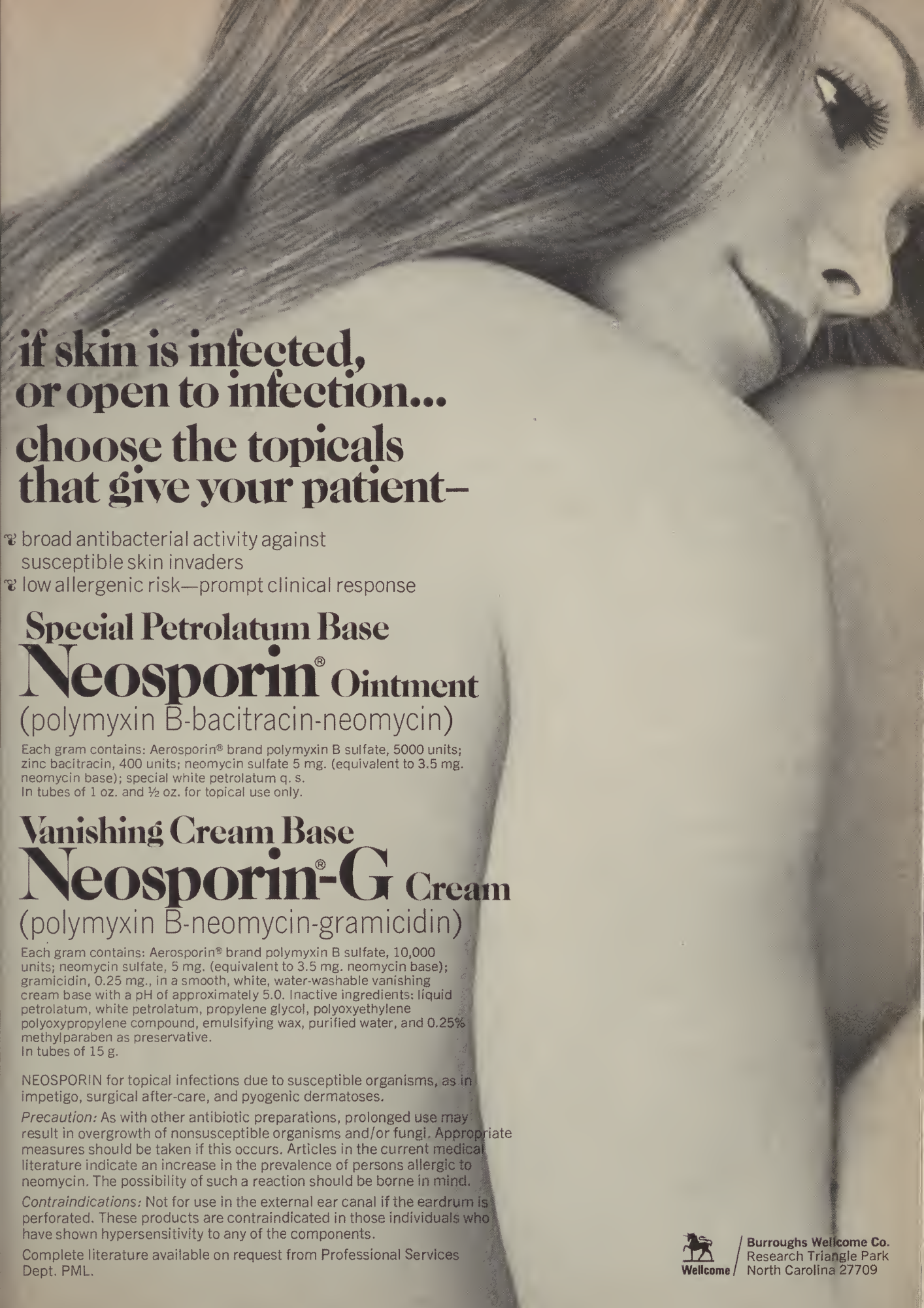
HOW SUPPLIED: *250 mg* and *500 m* Capsules—bottles of 24 and 100. *Ster Solution, 300 mg per ml*—2 and 10 ml vi and 2 ml syringe. *Syrup, 250 mg per 5* —60 ml and pint bottles.

*For additional product information, cons the package insert or see your Upjo representative.*

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(polymyxin B-neomycin-gramicidin)

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NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

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**Precautions:** Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
**Side effects:** Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.
**Dosage:** Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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**DeWITT E. DeLAWTER, MD, Chairman**
**MRS. FRANCIS C. MAYLE, Editor**

# WHO GETS MMPAC SUPPORT?

A question frequently asked by physicians is: "What are the factors upon which the MMPAC Board bases its support for a candidate?"

The first part of the answer is that all decisions are hard-nosed and pragmatic. The MMPAC Board knows that there is no room for personal, partisan feelings; their overriding concern is: "What is best for medicine?"

In every election somebody wins and somebody loses. Every candidate will have had the support of some physicians. These individuals may not be too happy with the Board's decision, if it didn't favor their man. It is important to remember that the Board receives the report of the district chairman, and involves itself in detailed study and spirited debate before it takes its vote. That vote is based on the following *objective* criteria.

DOES THE CANDIDATE HAVE AN HONEST AND REASONABLE CHANCE OF WINNING? PAC resources are limited, and there is involvement only with those candidates who have a real chance of success. We cannot afford to waste money on a clear loser, however meritorious he may be.

DOES THE CANDIDATE HAVE THE GENERAL SUPPORT OF PHYSICIANS IN THE DISTRICT? Are the district physicians interested enough in the candidate to help by raising money for him within the district and to aid in other candidate support activities?

WHAT ARE THE ACTUAL NEEDS OF THE CANDIDATE AND HOW SERIOUS ARE HIS NEEDS? Again, because PAC resources are limited, the Board tries to make its larger contributions to those campaigns where it can do the most good and where it may make the difference between winning and losing. A candidate who is almost sure of winning may receive nominal support. Where there is a close race between two men of markedly different outlook or philosophy, an effort will be made to give the better candidate a larger contribution.

When considering support for an incumbent office holder, other factors come into being.

HAS HE BEEN GENERALLY SYMPATHETIC AND SUPPORTIVE OF MEDICINE IN THE PAST?

WHAT ARE THE COMMITTEE ASSIGNMENTS OF THE INCUMBENT? This is where most of the work in Congress really takes place. Such committees as House Ways and Means, House Interstate, Foreign Commerce, Senate Finance, etc, handle most health legislation. Naturally, friendly incumbents serving on these committees receive special consideration.

DOES THE CANDIDATE HAVE IMPORTANT PARTY OR OTHER POLITICAL POSITIONS? WHAT IS THE LEGISLATOR'S SENIORITY? A senior member, a delegation chairman, etc, has political clout with others that must be an important political fact of life bearing on support.

With limited money to commit when all other factors are judged to be about equal, another important fact must be considered.

HOW WELL DOES THE DISTRICT STAND IN MMPAC MEMBERSHIP?

If all other things are about equal between two candidates from different districts, weight must be given to one if the physicians in his district have done a better job in building a high percentage of physicians who are MMPAC members.

THINK ABOUT THESE CRITERIA. HOW DO YOU MEASURE UP? HOW DOES YOUR DISTRICT MEASURE UP? SUCCESSFUL POLITICS CONSISTS OF PEOPLE ACTING TOGETHER TO SUPPORT A COMMON GOOD.

**MRS. KARL MECH**

All of the members of MMPAC, especially those who had worked so closely with her for so many years, were deeply grieved to learn of the death of Mrs. Karl Mech. She served MMPAC diligently, and we are deeply grateful. We wish to take this opportunity to express our sympathy to Dr. Mech and the family.

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**library**

# VALUED FINDINGS

Libraries ought never to boast about the monetary value of their collections, and we do not mean to boast here, but libraries have an obligation to preserve and maintain their collections for later generations of scholars. It was for this reason that Med-Chi began to weed its general book stacks a few years ago in order to segregate some of its important treasures.

The success of the project can be measured in one way by the fact that we have transferred approximately 10,000 volumes selected from the general collection to make up the new History & Rare Book Section of the Library. While these books no longer circulate (except with special permission of the librarian) they will be made more useful to scholars by their segregation, special care, availability, and by their eventual recataloging—already underway.

We recently compared our holdings with one of the most important rare book catalogs issued in the past decade by a specialist dealer in the field of medicine (Jeremy Norman, San Francisco, **Catalog One,** 1971). Of 404 items listed, Med-Chi's History & Rare Book Section has 151 (37%) which are valued in the Catalog at $47,675. Surely, it was good to have been able to withdraw these from general circulation and set them aside for future researchers.

Among the interesting volumes listed in this lot are Auenbrugger's **Nouvelle Methode . . .** (Paris, 1808), the second edition in French, but the first edition edited by the great Corvisart whose prestige "brought about universal recognition of the value of percussion"; then there is the first (Plattsburg, N.Y., 1833) edition of Beaumont's . . . **Observations on the Gastric Juice**; also, Sir Charles Bell's **Anatomy of the Brain** (London, 1802), one of the most beautiful works in neuroanatomy. We also have Bleuler's **Dementia Praecox** (Leipzig, 1911), that Zilboorg calls one of the most important contributions to psychiatry in the 20th century; and there is Bonet's first collection of systematized pathological anatomy, his **Sepulchretum** of 1679.

This is only a part of our holdings in the letters A and B in the Catalog's alphabetical arrangement. Med-Chi can certainly be proud of its fine historical collection. From time to time we will write in this column about other holdings in the History & Rare Book Section (we haven't even begun to talk about our manuscripts!).

LEE ASH
Library Consultant

**NOTICE TO ALL FACULTY MEMBERS**

At the last Council meeting, a change in the policy was approved regarding quantity of xeroxing permitted members. As of February 1, all members are allowed 50 pages of xeroxing per month without charge. This furnishes each member the same amount; before, Baltimore city members were charged for all xeroxing. This amount is not cumulative, so it behooves members to send their requests regularly each month rather than in one extensive list. Current copyright agreement does not allow libraries to make multiple copies.

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## NEW ACCESSIONS – BOOKS
## (Arranged by Subjects)

### ANESTHESIOLOGY

WO 200 .M6 **Modern trends in anaesthesia,** no.3, 1967. London, Butterworth.

WO 450 01 **Obstetrical anesthesia;** current concepts and practice. Edited by Sol N. Shnider, with 14 contributors. Baltimore, Williams & Wilkins, 1970.

### APHASIA

WL 340 .E8 Ewing, Sir Alexander William Gordon
**Aphasia in children.** With an introduction by E.D. Adrian. New York, Hafner Pub. Co., 1967.

### CEREBELLUM

WL 320 .M8 Mussen, Aubrey T.
**The cerebellum and red nucleus;** anatomy and physiology. New York, Hafner Pub. Co., 1967.

### CEREBRAL CORTEX

WL 307 .S4 Sholl, Donald Arthur
**The organization of the cerebral cortex.** New York, Hafner Pub. Co., 1967.

### DIAGNOSIS

QY 26 .P7 Preston, Joseph A.
**Biochemical profiling in diagnostic medicine.** By Joseph A. Preston and David B. Troxel. Tarrytown, N.Y., Technicon Instruments Corp., 1971.

### DRUG ABUSE

ZWM 270 .M4 Menditto, Joseph
**Drugs of addiction and non-addiction,** their use and abuse; a comprehensive bibliography, 1960-69. Troy, N.Y., Whitston Pub. Co., 1970.

### EPIDEMIOLOGY

WA 100 .M3 Maryland Regional Medical Program. Epidemiology and Statistics Center.
**Report on activities.** Baltimore, 1972.

### EVOLUTION

WE 705 .G7 Gregory, William King
**Our face from fish to man:** a portrait gallery of our ancient ancestors and kinsfolk together with a concise history of our best features. With a foreword by William Beebe. New York, Hafner, 1963.

### FOOD DRUG AND COSMETIC ACT

WA 697 .U6 U.S. Laws, statutes, etc.
**Federal food, drug, and cosmetic act as amended January 1971.** Washington, U.S. Government Printing Office, 1971.

### GENERAL PRACTICE

W 89 .B5 Bjorn, John C.
**The problem-oriented private practice of medicine;** a system for comprehensive health care. By John C. Bjorn and Harold D. Cross. Chicago, Modern Hospital Press, 1970.

### HEALTH INSURANCE

WT 30 .H4 **Health insurance for the aged:** amounts reimbursed by state and county. Washington, Social Security Administration. Office of Research and Statistics, 1969.

W 100 H4 Health Insurance Institute
**Source book of health insurance data.** New York, 1971-72.

### HISTORY OF MEDICINE

Hist. CH Diethelm, Iskar
**Medical dissertations of psychiatric interest printed before 1750.** Basel, New York, Karger, 1971.

Hist. Kd Hunt, James
**Stammering and stuttering:** their nature and treatment. Introduced by Elliott J. Schaffer. New York, Hafner Pub. Co., 1967.

Hist. Mca Noyes, Marcia C.
**As we build.** Reprinted from Celebration of the Centennial of the Library of the Medical and Chirurgical Faculty of the State of Maryland, 1931.

Hist. WL 385 .T4 Temkin, Owsei
**The falling sickness;** a history of epilepsy from the Greeks to the beginnings of modern neurology. 2d ed., rev. Baltimore, Johns Hopkins Press, 1971.

### LARYNX

WV 500 .N4 Negus, Victor E.
**The comparative anatomy and physiology of the larynx.** With a foreword by Arthur Keith. New York, Hafner Pub. Co., 1962.

### LUNG

WF 600 .H2 Hayek, Heinrich von
**The human lung.** Rev. and augm. by the author. Translated by Vernon E. Krahl. New York, Hafner Pub. Co., 1960.

### MALNUTRITION

WD 105 .M2 May, Jacques M.
**The ecology of malnutrition in the French speaking countries of West Africa and Madagascar.** By Jacques M. May, with the collaboration of Donna L. McLellan. New York, Hafner Pub. Co., 1968. (Food geography series, 6)

WD 105 .M2 May, Jacques M.
**The ecology of malnutrition of Northern Africa.** New York, Hafner Pub. Co., 1967. (Food geography series, 5)

### MEDICAL TECHNOLOGY

WK 200 .H25 Hamolsky, Milton W.
**Thyroid testing.** Philadelphia, Lea & Febiger, 1971. (Medical technology series)

WH 16 .K4 Kelman, George Richard
**Computer produced physiological tables for calculations involving the relationships between blood oxygen tension and content.** By G. R. Kelman and J. F. Nunn. London, Butterworth, 1968.

WG 26 .M4 **Mechanical devices for cardiopulmonary assistance.** Proceedings of a symposium held in Boston, Mass., March 1970, under the auspices of the Assoc. for the Advancement of Medical Instrumentation. Edited by R. H. Bartlett, P.A. Drinker, and P.M. Galletti. New York, Karger, 1971. (Advances in cardiology, v.6)

QY 26 .W5 Winstead, Martha **Instrument check systems.** Philadelphia, Lea & Febiger, 1971. (Medical technology series)

NERVOUS SYSTEM

WL 101 .H6 Hörstadius, Sven Otto **The neural crest;** its properties and derivatives in the light of experimental research. Facsim. reprint of the 1950 ed. New York, Hafner Pub. Co., 1969.

PHYSIOLOGY

QT 150 .A2 **Physiology of man in the desert.** By E. F. Adolph and associates. New York, Hafner Pub. Co., 1969. (Monographs in the physiological sciences)

POISON CONTROL CENTERS

Ref. WA 465 .N2 National Clearinghouse for Poison Control Centers. **Poison control centers: Directory.** Washington, D.C., U.S. Dept. of Health, Education, and Welfare. Food and Drug Administration. Bureau of Product Safety — Division of Hazardous Substances and Poison Control, 1971.

POISONOUS ANIMALS

WD 400 B8 Bücherl, Wolfgang **Venomous animals and their venoms, v.3.** Edited by Wolfgang Bücherl, Eleanor E. Buckley and Venancio Deulofeu. New York, Academic Press, 1971.

PSYCHOLOGY

WM 172 .A5 American Psychopathological Association. **Anxiety.** Proceedings of the 39th Annual Meeting of the American Psychopathological Assoc., New York City, June 1949. Edited by Paul H. Hoch and Joseph Zubin. New York, Hafner Pub. Co., 1964.

WS 105 .F6 Forrer, Gordon R. **Weaning and human development.** Roslyn Heights, N.Y., Libra Publishers, 1969.

WL 106 .K6 Knoll, Jozsef **The theory of active reflexes;** an analysis of some fundamental mechanisms of higher nervous activity. Translated by S. Koch. New York, Hafner Pub. Co., 1969.

BF 531 .M6 Mooseheart Symposium on Feelings and Emotions, Mooseheart and University of Chicago, 1948. **Feelings and emotions.** Edited by Martin L. Reymert. New York, Hafner Pub. Co., 1967.

PUBLIC HEALTH ADMINISTRATION

WA 22 .AA1 .D5 **Department of Health, Education, and Welfare regional office directory:** professional and administrative personnel. Washington, U.S. Govt. Print. Off., 1971.

SOCIAL MEDICINE

RA 82 B2 Baltimore (City) Health Department. **Annual report of the Department of Health, 1970.**

W 275 .AC2 .C2 California Medical Association. Committee on the Role of Medicine in Society. **Role of medicine in society.** Third progress report. San Francisco, Six Ninety Three Sutter Publications, 1967.

W 275 .AC2 .C2 California Medical Education and Research Foundation. Committee to Study the Role of Medicine in Society. **The role of medicine in society.** Second progress report. San Francisco, Six Ninety Three Publications, 1965.

W 62 .R6 **The role of medical societies in the United States.** Facsimile of periodical articles collected by the Archive-Library Department of the American Medical Association, for Douglas Carroll, M.D., Chief, Physical Medicine & Rehabilitation, Balto. City Hospitals. Chicago, AMA, 1968.

WA 900 .AA1 .U6 U.S. Department of Health, Education, and Welfare. **Towards a comprehensive health policy for the 1970s;** a white paper. Washington, U.S. Govt. Print. Off., 1971.

WS 16 .W4 White House Conference on Children and Youth, Washington, D.C. 1970. **Profiles of children.** Washington, U.S. Govt. Print. Off., 1970.

SPORTS MEDICINE

QT 260 .05 Olson, O. Charles **Prevention of football injuries;** protecting the health of the student athlete. Philadelphia, Lea & Febiger, 1971.

SURGERY

WO 32 .AA1 .W3 Wasmuth, Carl Erwin **Law and the surgical team.** By Carl Erwin Wasmuth and Carl Erwin Wasmuth, Jr. Baltimore, Williams & Wilkins, 1969.

TESTOSTERONE

WJ 875 .T4 **Testosterone.** Proceedings of the workshop conference held from April 20th to 22nd, 1967 at Tremsbüttel. Edited by Jürgen Tamm. New York, Hafner Pub. Co., 1968.

VITAMINS

WK 100 V5 **Vitamins and hormones;** advances in research and applications. New York, Academic Press, 1971.


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1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height .....

3. Electrical or other requirements: .....

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4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

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An Art and Hobby Exhibit will be held during the 174th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted. However, it is strongly urged that APPLICATIONS be received in the Faculty office BY APRIL 15.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, May 2, 1972. They must be removed on Saturday, May 6, before 1:00 PM. The Faculty cannot carry insurance on exhibits. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies should cover the exhibit. Entries should be submitted as early as possible.



HOBBY DISPLAY—Great interest was shown in the Art and Hobby Exhibit at the 1971 Annual Meeting of the Medical and Chirurgical Faculty.



## CALORIES / 1 Cup Prepared Soup*

| | | | |
|---|---|---|---|
| Beef Broth | 25 | Vegetable | 77 |
| Consomme | 33 | Tomato | 79 |
| Chicken with Rice | 49 | Cream of Asparagus | 80 |
| Chicken Gumbo | 55 | Cream of Chicken | 87 |
| Chicken Noodle | 62 | Beef | 99 |
| Chicken Vegetable | 68 | Cream of Potato | 105 |
| Turkey Noodle | 72 | Cream of Mushroom | 131 |
| Vegetable Beef | 75 | Green Pea | 131 |

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 536, Camden, New Jersey 08101.

# There's a soup for almost every patient and diet ..for every meal and, it's made by Campbell

# the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences in their activity levels and estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

*References:* **1.** Editorial: Oral Contraceptives: Which Pill for Which Patient? Patient Care *3*:90-115 (Feb.) 1969 and *4*:135-145 (June 15) 1970. **2.** Greenblatt, R. B.: Progestational Agents in Clinical Practice, Med. Sci. *18*:37-49 (May) 1967. **3.** Kistner, R. W: Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W: The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H.: Clinical Evaluation of Side Effects of Current Oral Contraceptives, J. Reprod. Med. *6*:50-55 (Feb.) 1971. **6.** Orr, G. W: Oral Progestational Agents: Therapy and Complications, S. Dakota J. Med. *22*:11-17 (Jan.) 1969.

## the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

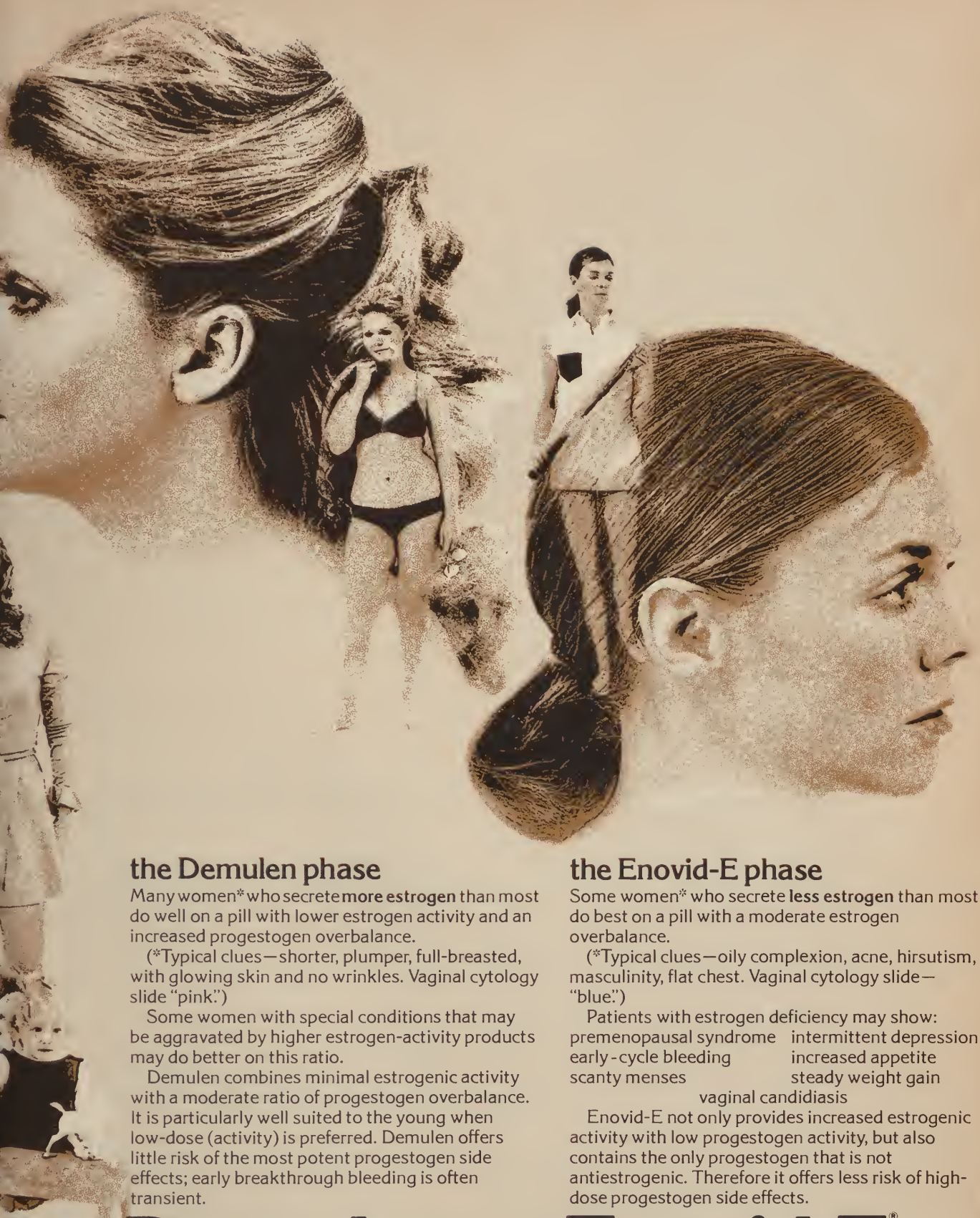
Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slight progestogen dominance. It has an excellent record of patient acceptance.

# Ovulen®

Each white tablet contains. ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information, see following page.



## the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

# Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Both Ovulen and Demulen are available in 21- and 28-pill schedules.

## the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

# Enovid-E®

Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

**Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.**

# for the 3 phases of Eve:

## a family of O.C. products

## Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

## Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in $T^3$ uptake values; metyrapone test and pregnanediol determination.

**References: 1.** Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study. Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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## Enovid-E®

norethynodrel 2.5 mg./mestranol 0.1 mg.

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

SEARLE **Enovid-E®**

brand of norethynodrel with mestranol

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P.O. Box 5110, Chicago, Illinois 60680
*Where "The Pill" Began*

271

# The girth control pill



# Tepanil® Ten-tab®

(continuous release form)

## (diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

**Contraindications:** Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

**Warning:** Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

**Adverse Reactions:** Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastraintestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopaietic system include two each of bone marrow depression, agranulacytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mauth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

**Convenience of two dosage forms:** TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

1-3325 (2876)

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# Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

- Prevents painful night leg cramps
- Permits restful sleep
- Provides simple convenient dosage — usually just one tablet at bedtime

**Prescribing Information—Composition:** Each white, beveled, compressed toblet contoins: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treotment of nocturnol and recumbency leg muscle cromps, including those ossocioted with orthritis, diobetes, varicose veins, thrombophlebitis, orteriosclerosis ond stotic foot deformities. **Contraindications:** Quinomm is contraindicoted in pregnoncy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinol cromps in some instonces, ond quinine moy produce symptoms of cinchonism, such os tinnitus, dizziness, ond gostrointestinol disturbonce. Discontinue use if ringing in the eors, deofness, skin rosh, or visual disturbonces occur. **Dosage:** One toblet upon retiring. Where necessory, dosage may be increosed to one tablet following the evening meol ond one toblet upon retiring. **Supplied:** Bottles of 100 ond 500 toblets.

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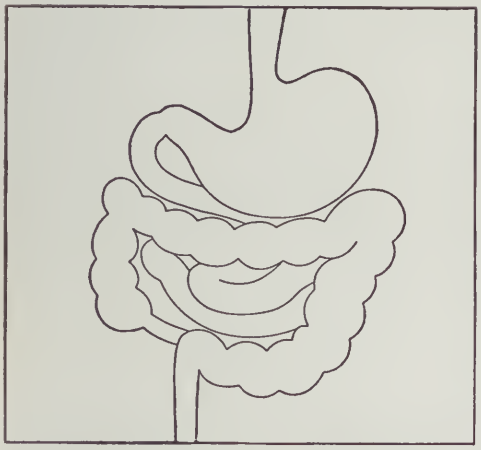
Trodemork: Quinomm

# Quinamm

(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps.

# in "Gasspastic" conditions



The GI tract in spasm is commonly a "gas trap."

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that "lyses" gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gastritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

**Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.**

Sidonna can do more for your "gasspastic" patient. Try him on 1 or 2 tablets before meals and at bedtime.

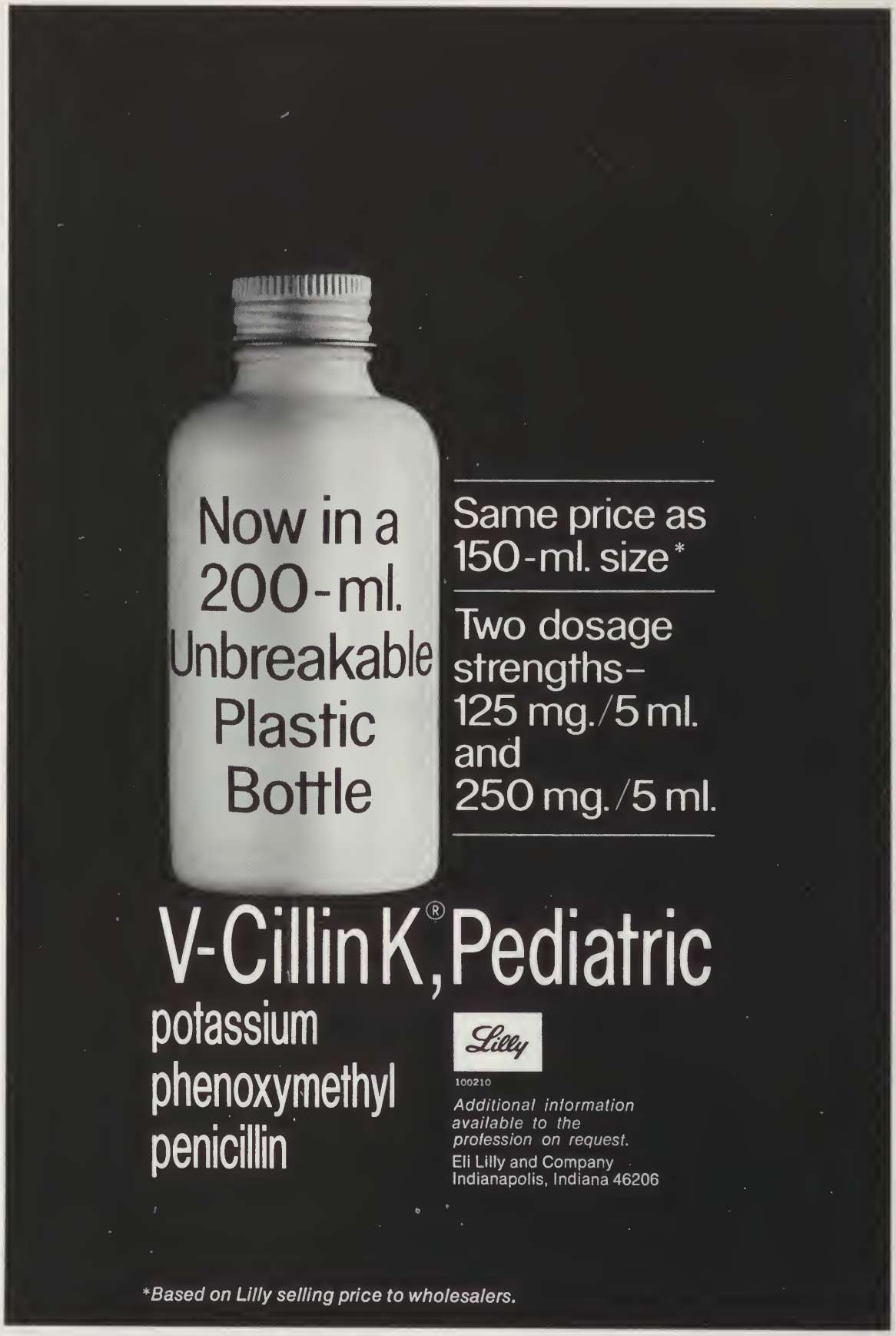
# Sidonna®

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# can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.
**Side Effects:** Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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Same price as 150-ml. size*
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# HISTORY AND CURRENT ACCOUNT OF MED-CHI ROLE IN DRUG ABUSE IN BALTIMORE AND IN MARYLAND

**LOUIS J. KOLODNER, MD**
**Chairman, Mediation Committee**
**Medical and Chirurgical Faculty**
**of the State of Maryland**
**Baltimore**

Although it is not generally known, the Medical and Chirurgical Faculty has exhibited an early interest and conducted extensive investigation into the use and abuse of drugs. This interest preceded even state or federal regulatory legislation in this field. In fact the Faculty's concern is still maintained despite preemption in this field by the plethora of state authorities newly created as a result of the outcry by a concerned lay public and by the activity of this society.

In 1967 records show that the Faculty was asked by the Department of Parole and Probation for its guidance and advice in a methadone program being operated under the auspices of Emmett P. Davis, MD, on Belair Road in Baltimore City. Dr. Davis, having read of the success of Drs. Marie Nyswander and Vincent Dole in New York City, determined he would do something to assist hard-core addicts who were being turned away from the offices of physicians where they sought treatment.

This was the first such program in Maryland. The Faculty, recognizing its medical responsibility in this area, named a special group, through the Mediation Committee, to evaluate this program and make recommendations for its continuance. Such recommendations would be communicated to local law enforcement officials as well as to those involved in the enforcement of drug abuse legislation. This special group held a round-table discussion with representatives of the Man Alive drug project to which representatives of the many disciplines were invited. All recognized the need for a treatment program for hard-core addicts. The subcommittee's recommendations, which were later approved by the Faculty's Mediation Committee, consisted of the following:

> A fool proof system should be developed to prevent the sale of methadone tablets "on the street" with its potential for creating additional addicts, particularly in the teenage group presently on one of the greatest "drug kicks" ever seen.
>
> Proper records should be maintained so as to learn the number of "cured" addicts that have benefited from the program. At present, it is reported that only six addicts have graduated from the program but none can be found to ascertain their current dependence on drugs.
>
> In brief, the Faculty feels that there is a potential for this type of program which might assist the addict to be cured. If and when improvements in the program are made, as it is understood such improvements will be suggested by the State Department of Mental Hygiene, the program can then be reevaluated in the light of the circumstances at that time.

Impressed by the success of the Man Alive Research Program, other physicians in the community felt qualified to follow in the footsteps of Dr. Davis. But some of them became easy marks for addicts who wished methadone prescriptions. As a result, in a short period of time, nearly a dozen physicians were seeing large numbers of so-called patients who were trying to withdraw from heroin addiction and were seeking medical help. Doctors began to prescribe methadone in tablet form to such individuals, the medication being sufficient for a week's withdrawal dosage.

At this juncture, city, state, and federal drug abuse agents approached the Faculty with requests that these practices be reviewed inasmuch as large amounts of this drug were reaching the black market.

The Mediation Committee then established a Subcommittee on Narcotic Prescribing Practices of Physicians, which met early in 1969 and at which meeting each of the prescribing physicians was asked to present his viewpoint on usage of methadone and treatment regimen being used. Without exception each doctor revealed a paucity of real understanding about the

programs in operation at that time in New York. No one for instance was aware of the addict's ability to lie convincingly, and more importantly no one was cognizant of the effective controls being exercised in the New York program and the need for such controls.

Out of this came a subcommittee recommendation (with concurrence by the Mediation Committee) that all physicians be directed to cease treating addicts in this way. Each did, and some expressed great relief at being so directed.

The subcommittee however recognized this was a serious and burgeoning problem. It was determined that some positive effort should be made to develop a set of guidelines for the Man Alive program and for physicians and other programs that might develop in an attempt to meet the growing need for treatment centers for addicts.

Representatives of the subcommittee visited the programs in New York City where the methadone program originated, were functioning, and were accumulating experience in the use of this drug.

The programs were studied in depth, interviews were held with both physicians and patients, and a report was subsequently made to the subcommittee. A copy of this report is available.

Much was learned from this experience. The subcommittee was able to set up strict, high-standard Guidelines for Treatment of Narcotic Addicts with Methadone in the State of Maryland. This confirmed the previous decision of the subcommittee which generally banned physicians in office practice from operating such treatment programs. The guidelines could only be followed by sophisticated, well-run, well-staffed treatment programs, and under proper surveillance.

The subcommittee also felt the necessity for self-education. With this in mind a series of sessions was held to which representatives of state and federal drug abuse agencies were invited. In addition liaison was established with State Police as well as Baltimore City Police Department officials. It must be recognized that law enforcement officials were most skeptical of the purpose of the drug abuse treatment programs and were of the opinion these programs were being run for the convenience of the addicts. The Judiciary however was supportive of these efforts.

The subcommittee felt the need to inspect the programs on an operational basis. On-site inspections were arranged of MAN ALIVE, PROJECT ADAPT (PROVIDENT HOSPITAL), JOHNS HOPKINS HOSPITAL DRUG ABUSE PROGRAM, FRIENDS OF PSYCHIATRIC RESEARCH, BALTIMORE CITY HOSPITALS' CRISIS CLINIC, and others. Reports of these inspections are available.

In these early stages, with no federal or state regulatory guidelines, the Faculty felt it incumbent that guidelines be developed. It was only by force of its influence that these programs were kept within reasonable bounds in operation as well as inclusion of addicts who were truly seeking help.

It is a well-known fact that addicts, when undergoing withdrawal symptoms or faced with a lack of supply of drugs, will agree to almost anything. With this in mind, changes are continuous in the membership of such programs.

Early in this period, the Faculty recognized the necessity of some sort of liaison between the drug programs — not only to ensure that addicts were enrolled in only one program, but to exchange information on procedures and other developments as they occurred. At the suggestion of the Faculty, but on their own initiative, the programs established the Medical Coordinating Team whose purpose is to meet on a regular basis, compare experiences, and to discuss mutual problems. This group was recently funded by the Regional Medical Program. It was legally incorporated, as a nonprofit group, in March 1971.

While a yeoman job had been done by the Faculty in adequately controlling the filtering of drugs into the black market through physicians' offices in Maryland, there still existed a problem with several physicians located in the District of Columbia. Attention was turned to this problem and the District Medical Society, Federal Authorities, and Congressmen and Senators from Maryland were contacted about it. This is still a continuing problem, although diminished from its previous proportions.

Educational programs were started, including a symposium on "Drug Abuse — The Dangers and Responses," held by the Faculty at its Semi-annual Meeting in Hershey, Pa., on September 5, 1969. The speakers on this program were The Honorable David Ross, Judge, Supreme Bench of Baltimore City; Steven V. Sklar, LLB, Delegate, General Assembly of Maryland, Fifth Legislative District, Baltimore City; and Harvey Gollance, MD, of New York City, Associate Director, Beth Israel Medical Center, and Administrator, Methadone Maintenance Treatment Program. Also included in this program were

comments and remarks by two addicts who were being maintained through Dr. Gollance's program. At this time an appeal was made to physicians for their individual participation in treatment programs.

The subcommittee, in becoming heavily involved in these areas, became aware of the fact that some physicians were involved as drug abusers. As a consequence the group was charged with evaluation of such physicians, their future potential as physicians, and the possibility of assisting them to become free of drug dependence.

Concurrently with this phase of activity, the subcommittee turned its attention to the medical treatment being provided to jail inmates, including those who had a drug-addiction problem. This was accentuated because of the incarceration of individuals who were participating in methadone maintenance programs and the consequent detoxification of such individuals jailed while awaiting trial.

Visits were made by subcommittee members to the Baltimore City Jail and the Maryland State Penitentiary to study and suggest improvements in the detoxification and treatment of inmates, as well as those awaiting trial. Much opposition and reaction were raised to reform attempts in these areas by city jail authorities. The state prison authorities and personnel were most cooperative.

Attempts were made by the subcommittee to obtain more psychiatric services for inmates at the Baltimore City Jail. Slight progress was made in this area by tapping more resources and improving organization of this to some extent. This needed further resolution but was blocked by lack of funding.

Liaison and communications were established and maintained by the State Drug Abuse Authority and with State Legislators who were concerned with this problem.

A cooperative relationship was also established with the State Department of Health and Mental Hygiene, largely through the efforts and continued interest of Mr. John Sargeant.

Attempts were made to get greater appropriation from the State of Maryland for treatment programs and to increase the facilities for treatment of hard-core addicts. Treatment programs were revisited and improvements in their operation noted. Where deficiencies still existed, they were brought to the attention of those in charge of the programs.

Additional meetings were scheduled with representatives of state, city, and federal narcotics authorities. A special session was held with the Supreme Bench of Baltimore City, Probation and Parole authorities, and other groups that have a vital interest and concern with this problem.

In February 1971 an all-day session was held, primarily to establish good liaison between the Faculty and involved groups. It was hoped that mutual problems in the handling of hard-core addicts by the courts and other groups could be resolved by this session. Considerable planning went into this session which had as its program the following:

MODERATOR:
HONORABLE STEVEN SKLAR
Maryland House of Delegates

9:00 A.M.
Greetings

9:10 A.M.
INTERPRETATION OF MARYLAND'S DRUG ABUSE STATUTES
Honorable Steven Sklar

9:30 A.M.
RESOURCES AVAILABLE TO THE COURTS IN MARYLAND
Joseph Berman, MD

10:00 A.M.
THE WASHINGTON D.C. SCENE—ITS TREATMENT PROGRAM
Robert duPont, MD

10:30 A.M.
Coffee Break

10:50 A.M.
A PROFILE OF THE DEPEATED OFFENDER
B. D. Smith, MD
Medical Officer
Department of Correctional Services

11:15 A.M.
VIEWS OF THE LAW ENFORCEMENT AGENCIES
Robert M. Stutman
Bureau of Narcotics & Dangerous Drugs

11:30 A.M.
COMMENTS OF THE STATE'S ATTORNEY OF BALTIMORE CITY
Honorable Milton B. Allen

11:50 A.M.
SUMMARY
Rev. Frederick J. Hanna

12:15 P.M.
Break for Lunch

12:30 P.M.
THE JUDGE'S DILEMMA
Judge J. Gilbert Prendergast

2:00 P.M.
DISCUSSION GROUPS

3:00 P.M.
Frank A. Caprio, MD
Chairman, Maryland Advisory Council on Drug Abuse

3:10 P.M.
SUMMARIES OF DISCUSSION GROUPS

3:30 P.M.
CONFERENCE WRAP-UP
Rev. Frederick J. Hanna

4:00 P.M.
ADJOURNMENT

As one of its more recent activities, the subcommittee developed, through an ad hoc committee, a Comprehensive Drug Abuse Emergency Treatment Manual. This was a joint effort with the State Drug Abuse Administration. The special group consisted of:

Stephen A. Hirsch, MD, Chairman
Joseph I. Berman, MD
Gerald D. Klee, MD
Stuart Nightingale, MD
Huell E. Connor, Jr., MD
Charles Carpenter, MD

This manual is to be kept in all emergency rooms and drug treatment facilities. It is to be used for treatment in cases of overdoses, drug detoxification, and as a reference on cases of drug abuse. The manual contains high-quality material and required much thorough effort and work.

The subcommittee continues to meet on a regular basis and deals with many and varied problems of drug abuse by patients, populace, and physicians.

In some cases physicians have been referred to other committees for action to be taken in connection with their licensure. The subcommittee has endeavored at all times to aid law enforcement personnel and to eliminate black market drug activities.

The executive director is a constant help to the subcommittee. He is our liaison with the Governor, state and federal agencies, and the General Assembly in Annapolis.

Finally, in September 1971, two resolutions were introduced in the Council and the House of Delegates for even stricter and more restrictive use of both methadone and amphetamines by physicians and the populace.

The Faculty is rightfully proud of the role it has played in pioneering and pursuing its resolute course to combat the inequities and destructive drug problem in our state. We have cooperated with county societies in these areas. Much praise must be given to those members of the Subcommittee on Medical Treatment and Drug Programs, the Mediation Committee, and the executive director—all of whom played vital roles in this pioneering effort of the Faculty.

Thanks and appreciation should also be extended to the Faculty's officers, councilors, and members of the House of Delegates for this fine contribution to the state and its citizenry in attemping to help solve the drug abuse problem; and to aid law enforcement, treatment, prevention, education authorities, and the Judiciary in this unfortunate and potentially destructive epidemic.

Current members of the Subcommittee, which has been renamed as the Subcommittee on Medical Treatment and Drug Programs, are as follows:

Theodore Patterson, MD, Chairman
John B. De Hoff, MD
Stephen A. Hirsch, MD
Hilary T. O'Herlihy, MD
Gerald D. Klee, MD
Joseph I. Berman, MD
Clayton Norton, MD
Stanley M. Rosen, MD

## Summary of Faculty Achievements in Drug Abuse Activity

1. The Medical and Chirurgical Faculty of the State of Maryland, through its Mediation and Drug Abuse and Medical Treatment Committees, recognized early the implication of the impending and disastrous drug epidemic locally and nationally; and attempted to alert, organize, educate, and initiate action by physicians, and the public; and by local, state, and federal agencies to meet these problems.

2. Your state medical society set up guidelines for the treatment of drug addicts and heroin addiction in Maryland. These guidelines served as a model for the federal government and other states in this country.

3. Liaison was established between our own state medical society and the federal, state, and local narcotics and law enforcement agencies to effect proper and efficient surveillance of physicians and the public regarding drug and narcotic use and abuse.

4. Communication and educational liaison was established by this society with

a) the Medical Coordinating Team (combined treatment programs of Baltimore City),
b) the Maryland State Drug Abuse Administration, and
c) all individual drug treatment programs in Baltimore City (and also some of the counties of the state).

5. The Medical and Chirurgical Faculty has encouraged and aided the initiation of new drug abuse treatment programs. It has also tried to aid in obtaining funds from private, state, and federal agencies for existing treatment programs.

6. Several symposia and panels of experts were organized by this society for the purpose of education in drug abuse of

a) physicians;
b) judges and the legal profession;
c) legislators;
d) correctional institutions and personnel;
e) federal, state, and local law enforcement and narcotic agencies;
f) patients and the general public;
g) social agencies in city and state; and
h) Maryland State Drug Abuse Administration and its personnel.

7. Constant and ongoing physician surveillance and education was maintained by the special committees of this society.

8. This state medical society, by resolutions recently adopted in its House of Delegates and its Council, tightened restrictions on the use of methadone and amphetamine compounds as prescribed by physicians.

9. The Medical and Chirurgical Faculty hopes and plans to help initiate and stimulate the establishment of an indepth physician training program in order to prepare the practicing physician to be well informed and fully capable of rendering adequate high-quality care and treatment of drug addiction and related problems.

10. This society, in collaboration with the Maryland State Drug Abuse Administration and through the untiring efforts of members of the Medical Coordinating Team and Drug Treatment Committee, composed, wrote, printed, and distributed an Emergency Drug Treatment Manual. This manual has been distributed to all hospitals in Maryland. It has been sent to all emergency rooms, drug treatment programs, and to those interested or involved in the drug abuse problems in this state. This treatment manual also received nationwide distribution.

11. This society has been active in trying to obtain proper and humane medical treatment of inmates in correctional institutions in this city and state. Its committees have recommended proper accepted and preferred detoxification methods and other modes of medical therapy and management to medical personnel in correctional institutions.

12. The Medical and Chirurgical Faculty will constantly follow and be interested in research and new developments in the drug abuse field. It will maintain a flexible, progressive, and dynamic attitude in meeting the drug abuse problems on the horizon. The Faculty will maintain high standards and encourage more physician interest and involvement in prevention and treatment of drug abuse in the City of Baltimore and State of Maryland.

13. Since completion of the inspections and reports referred to in the appendices, all of the treatment programs for drug abuse and narcotic addiction mentioned in Baltimore have shown a constant upgrading in standards, equipment, organizations, and quality of care generally. These programs have made great efforts to give the best of care and are to be commended.

For those interested in further study of these reports, a listing follows of those appendices available for review in the Faculty office.

I Report of the Subcommittee on Narcotic Prescribing Habits of Physicians

II General Outline of the Man Alive Program and Its Operation—April 1969

III Report on visit to Man Alive Committee meeting—April 1, 1969

IV Report on Visit to Project Adapt—April 21, 1969

V Notes on Visit to Phipps Psychiatric Unit of Johns Hopkins Hospital—April 30 and May 7, 1969

VI Report on Visit to SAND—May 6, 1969

VII Report on Visit to Friends of Psychiatric Research Clinic—May 15, 1969

VIII Report on Visit to Crisis Center, Baltimore City Hospitals—May 23, 1969

IX Report on Visit to Man Alive Program—October 14, 1969

X Report on Visit to Project Adapt—November 19, 1969

XI Report on Visit to Crisis Clinic, Baltimore City Hospitals—December 22, 1969

XII Report on Visit to Johns Hopkins Drug Abuse Program—January 19, 1971

XIII Report on Visit to Project Adapt—May 10, 1971

## Med-Chi Committee Members and Staff Personnel Involved In Drug Abuse Activity

**1967 — Mediation Committee:**
Wolcott L. Etienne, MD, Chairman
John M. Dennis, MD
Howard F. Kinnamon, MD
Charles F. O'Donnell, MD
M. McKendree Boyer, MD
Robert vL. Campbell, MD
John T. Chissell, MD
J. Morris Reese, MD
Russell S. Fisher, MD
Robert B. Goldstein, MD
Lewis P. Gundry, MD
Louis J. Kolodner, MD
John F. Schaefer, MD

**1968 — Mediation Committee:**
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Katherine H. Borkovich, MD
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John M. Dennis, MD
Robert B. Goldstein, MD
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Henry C. Mellette, MD
Charles F. O'Donnell, MD
Hilary T. O'Herlihy, MD
J. Morris Reese, MD
William J. Sullivan, MD
Henry C. Welcome, MD

**1969 — Mediation Committee:**
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Katherine H. Borkovich, MD
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Roland T. Smoot, MD
William J. Sullivan, MD
Henry C. Welcome, MD

Robert vL. Campbell, MD
J. Morris Reese, MD
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Richard D. Bauer, MD
Russell S. Fisher, MD

**1970 — Mediation Committee:**
Lewis P. Gundry, MD, Chairman
Richard D. Bauer, MD
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Hilary T. O'Herlihy, MD
J. Morris Reese, MD
Arthur G. Siwinski, MD
Roland T. Smoot, MD
William J. Sullivan, MD
Henry C. Welcome, MD

**1971 — Mediation Committee:**
Louis J. Kolodner, MD, Chairman
Richard D. Bauer, MD
Katherine H. Borkovich, MD
Henry A. Briele, MD
Vernon R. Croft, MD
Russell S. Fisher, MD
Robert B. Goldstein, MD
Hilary T. O'Herlihy, MD
J. Morris Reese, MD
Arthur G. Siwinski, MD
Roland T. Smoot, MD
William J. Sullivan, MD
Henry C. Welcome, MD
C. Vernon Williamson, MD

**1968 — Subcommittee on Narcotic Prescribing Practices:**
Louis J. Kolodner, MD, Chairman
J. Morris Reese, MD
Henry C. Mellette, MD

**1969 — Subcommittee on Narcotic Prescribing Practices:**
Louis J. Kolodner, MD, Chairman
J. Morris Reese, MD
Henry C. Mellette, MD
John B. De Hoff, MD
Stephen A. Hirsch, MD

**1970 —** Name of Subcommittee changed to **Subcommittee on Medical Treatment and Drug Programs**

**1971 — Subcommittee on Medical Treatment and Drug Programs:**
Louis J. Kolodner, MD, Chairman
John B. De Hoff, MD
Stephen A. Hirsch, MD
Hilary T. O'Herlihy, MD
Theodore Patterson, MD
Gerald D. Klee, MD

**Drug Abuse Seminar Planning Committee:**
(February 20, 1971)
Louis J. Kolodner, MD, Chairman
George Leight, Assoc. of Social Workers
James Nolan, State Bar Association
Col. Maurice D. duBois, Baltimore City Police Dept.
Sgt. Frank Mazzone, Maryland State Police
Rev. Frederick J. Hanna, Maryland Public Health Assoc.
Joseph Caskey, Drug Abuse Authority
Dr. David, Dept. of Correctional Services
B. D. Smith, MD, Dept. of Correctional Services
Earl Kraft, Dept. of Correctional Services
Joseph I. Berman, MD, Medical Coordinating Team
Frank G. Pappas, Bureau of Narcotics and Dangerous Drugs
Judge Albert Sklar, Supreme Bench of Baltimore City
Robert M. Stutman, Bureau of Narcotics and Dangerous Drugs

**Ad Hoc Committee for Drug Abuse Emergency Treatment Manual:**
Stephen A. Hirsch, MD, Chairman
Huell E. Connor, MD
Stuart L. Nightingale, MD
Joseph I. Berman, MD
Gerald D. Klee, MD
Charles C. Carpenter, MD

All committees were staffed by Mr. John Sargeant and Mrs. Constance Galton.


## Acknowledgement

The author gratefully acknowledges and wishes to thank Mr. John Sargeant for his kind aid in the preparation of this paper, collation of data, and for making accessible records and minutes of the Medical and Chirurgical Faculty.

The author also thanks Mrs. Constance Galton and her staff for the invaluable secretarial aid rendered in preparation of this paper.



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# THE YOUTHFUL DRUG ABUSER: SOME CONSIDERATIONS FOR TREATMENT

**MAUREEN McCARTHY, PhD**
**Director, Epoch House**
**Research Psychologist**
**Maryland Psychiatric Research Center**
**Friends Medical Science Research Center, Inc.**
**Baltimore**

The cult of experience is a prevailing option and a fundamental choice for many of today's youth. Experience is exalted to the detriment of trust; social responsibility is compromised by radical pragmatism — everything must be tried. There are few limitations, still fewer ground rules for experimenting and often vague or nonexistent expectations between the experience and the long-range implications for personal development.

Such a situation may aptly describe the drug abuser, particularly the narcotic addict. Drugs give the addict his style of life, his "thing," his means of self-expression, and to destroy this image is to destroy himself. Thus he faces an ignominious future because life is a distorted here and now, or a continuous cycle of gratification seeking. This pattern of self-seeking and self-centered behavior is part of the abuser's flight from maturity and responsibility. His past, with its failures and frustrations, contributes to further encasement in the security blanket of dependency provided by drugs. Drugs then become the only reality on the highway of disaster; therapy*, however, may change this blueprint to the future.

Drug abuse and drug addiction are oftentimes considered equivocal or synonymous terms. For Goldhill (1971, p4), there is significant difference between the two. Drug abuse is the more comprehensive term extending to addictive and nonaddictive drugs; as such, physical addiction and psychological habituation are included. In and of itself, drug addiction refers to the physical craving for the drug.

This paper is concerned with the theoretical and practical approaches to the treatment of the youthful drug abuser. A perusal of the literature reveals a dearth of information in this area, particularly in the treatment of the female drug abuser. The findings reported herein span a scope of several decades with the bulk of the references covering the years 1965 to 1971. Since youth culture is a happening, the information culled will hopefully shed some light on these questions:

Who is the youthful drug abuser?

What constellation of factors have produced this syndrome?

Is narcotic addiction inevitable?

Is minimal intervention enough?

Is recidivism equivalent to real failure in the strict sense?

What are the pitfalls to avoid so as not to turn off the youthful abuser?

What treatment modalities are being utilized?

## Who is the Youthful Drug Abuser?

The youthful drug abuser is a juvenile who continuously experiments with nonaddicting substances and, in some instances, narcotics. The adolescent marijuana smoker, the juvenile glue sniffer and the more daring multiple drug abuser are all youthful drug abusers. Narcotic addicts are described as hard-core users whereas a reefer addict is termed a soft-core user. The popular concept of a drug abuser as being one who is deprived, underprivileged, or poor has more recently been altered by the fact that addiction has rapidly become a problem of the middle and upper classes. Poverty and affluence together parade the highway of disaster. Both sexes and varying degrees of intelligence, as well as urban and rural residents, are represented by this severe emotional disturbance. The abuser and the addict are sick persons because they have failed to make a meaningful response to reality. Thus the reasons ascribed to marijuana use include: "curiosity, youthful thrill seeking, a desire to be 'in,' and a wish to demonstrate independence from a generation whose drug of choice is alcohol," (Marihuana Thing, 1968).

* Recommended: "Drug Use: Symptom, Disease, or Adolescent Experimentation—The Task of Therapy."

Adolescence is at best a tumultuous time. For the youthful drug abuser, turbulent mood swings run the gamut from being "up tight" to self-satisfied narcissism or a hang-loose attitude. The abuser's hang-up is not how to deal with reality but how to evade it. For Levy (1968), drugs provide teenagers with "sanctuary and illusion"; therapy must enable them to accept their own existence as a process of becoming. In accenting the alienation of the drug abuser Miller (1969) states we are confronted by an individual estranged from himself and from society; reconciliation is the formidable and transforming task assigned to therapy.

### What Factors Have Produced This Syndrome?

The causes associated with drug abuse are complex and varied, though sterile relationships with others seem to lead the list. Relationships do create relational responses, for all individuals have within them the capacity to generate or destroy meaning in the lives of others. Encounter groups have been termed "soul groups" for within them relationships undergo microscopic examination and redirection (Burton, 1970; Rogers, 1970; Siroka, et al, 1971; Schutz, 1967; Howard, 1970). According to Sabath (1964), a major problem in the treatment of any drug abuser would commence with the building of a relationship which is dynamic enough to mobilize and then crystallize the interplay between resistance and transference. Gottschalk et al (1970), Goldhill (1971), Cameron (1968, p1270), Holden (1966, p34), and St. Pierre (1969, p102), suggest abuse is a form of escape, a contention strongly supported by the abuser's lack of maturity in responding to school regulations and family affairs.

Factors such as an erratic disposition or unintegrated personality traits become the springwell for the poor ego strength that usually results. Since the infant is not born with a personality, the raw ingredients are molded by significant others, especially during infancy and childhood. If the child perceives or experiences rejection, either overtly or covertly, the self-concept will be appreciably negative. A poor self-image often leads to impoverished actualization of one's real potential. When this is combined with a stressful situation, the youthful abuser tries to alleviate his anxiety by the soothing effects of a quick "high" which only a drug can create (Bender, 1963; Lombardi, 1969; Robbins, 1967).

Why does the youthful drug abuser turn to devices and not to people? The more initiated one becomes in the drug subculture, the more one is caught in a circuitous maze — denegation and self-destructive impulses become increasingly manifest and ingrained in the personality (St. Pierre, 1971; Denison, 1971). Oddly enough personality "defects" and societal ills vie as top contenders for research. The implication seems to be if you solve both then you eradicate the drug problem.

Egan (1966) poses a more serious dilemma— that of the unspirited. He focuses on addiction as a spiritual problem because the spirit of the abuser is so consumed that he no longer wills for anything but drugs. Is the real cause of addiction impersonalization and materialism, or a clear lack of differentiation between real meaningfulness and passing attractiveness, between momentary pleasure and true happiness, between the reassurance of a good home and the tantalizing bright lights of today's show biz establishments?

### Is Narcotic Addiction Inevitable?

The fact that drug abuse is peer instituted is not new (Suchman, 1968); that it is associated with disenchantment or dissatisfaction with life is cause for concern. Perhaps the most insidious ill associated with marijuana use today is the marijuana-induced loss of goals and ambition (Louria, 1968, p106). If the marijuana user feels he's making it with his peer group then he will most likely use its argot (Stephenson and Scarpetti, 1968), and adhere to its standards. The impact of sanction by accepted peer group leaders has been cited by Klein and Phillips (1968, p144), as a possible clue to drug control. On the other hand, the community ideology may not only support but encourage drug abuse (Feldman, 1968).

If such is the case, the nonaddicted member of the community may be faced with another type of emotional problem — social ostracism. In essence, individuals commit themselves to the set of values maintained by their primary group. Such an affiliation shapes their emotional response and their self-concept (Polsky, 1962, p18). Unorthodox philosophies and unassimilated value systems (Unwin, 1968) are germane to drug abusers as another form of acting-out against tradition, conservatism, and "the establishment."

Goode (1969) provides some interesting observations on subcultural conformity: 1) experimentation with other drugs increases in proportion to increased marijuana smoking; 2) a linear relationship exists between marijuana use and the use of hallucinogenic drugs; 3) in the marijuana cult to be "hung up" or "strung out" on

hard drugs is to invite sanction for losing your cool. A confirmed marijuana smoker may see esoteric value in LSD and, at the same time, shy away from hard drugs. In a study of the marijuana users' preference for drugs, Whitehead, et al (1970, pp6540-6541) found a marked preference for tobacco (86.4%), alcohol (83.5%), stimulants (37.7%), LSD (30.8%), with descending preferences for tranquilizers (24.4%), other hallucinogens (22.8%), barbiturates (21.6%), glue (18.4%), and with the least preferred drug being opiates (17.3%).

Specialists in the area of drug addiction, while admitting the popularity of marijuana or pot among youth, are becoming aware of the ever increasing use of heroin or of hallucinogens such as LSD (Milbauer and Leinwand, 1970). Is marijuana then a stepping-stone for heroin? For Barber (1970, p101), there is no substantial or unequivocal proof to show linkage; more centitude is shown by Nowlis (1969, p100), who maintains that the great majority of cannabis users do not progress to heroin; and Blumer's position (1967, p73), is that the marijuana subculture has strong prohibitions against heroin and other narcotics. Complicating the entire issue of drug usage are multiple interrelated factors such as intelligence, achievement, social pressures, aspirations, need for approval, and ego strength. Internal vs external control of reinforcement is an intrapersonal variable, appreciably manipulated by the locus of control (Lefcourt, 1966). Conceivably then, the peer group leader can orient members towards or away from the drug culture.

In a special study conducted during September and October 1968, three patterns of drug use were identified (Drug Abuse Study, 1969, p154):

1) Experimental — includes those who had a single disagreeable experience with drugs, and those who have taken drugs on several occasions.
2) Habitual-intermittent — are those who take drugs regularly on weekends. Here, drug taking is group oriented and generally occurs at parties or in a social setting.
3) Habitual-daily — are truly drug oriented and include habitual glue-sniffers, heroin addicts and "super-experimenters".

Knowing the norms of the marijuana cult is important for those working with the youthful drug abuser. Identification of a neophyte marijuana user vs a multiple drug experimenter will lend a totally different perspective to the kinds of treatment undertaken and the expected prognosis.

### Is Minimum Intervention Enough?

Minimum intervention may win the battle or the momentary crisis; however it is short-sighted if it is not part and parcel of a comprehensive therapeutic, community-oriented program. By comprehensive is meant more than a plan for detoxification; mere survival techniques are not adequate. A network of ongoing interdependent agencies must exist as a safeguard to situational stresses posed by later development problems, such as draft and marriage. For Rubin (1969, p24), a residence facility should be one phase of a multidimensional youth service program.

The central core of any rehabilitative effort must enlist the full cooperation and empathy of the family and the community for it was within these environments the youth's problems began and the "cure" must be nurtured in the same environment. In the past, moralistic evaluation, stereotyping, and the community's punitive policies have often compartmentalized and retarded the treatment of the addict as a whole person (Brotman et al, 1965).

The term "therapeutic" involves a twofold consideration: therapeutic effect vs therapy as such. "Has it really helped?" is implied by the former while theoretical orientation emerges in the latter. If we are truly concerned with the therapeutic effect, we are entering the realm of feelings and emotions. In essence, we are engaging in a search for the uniqueness of the other or the qualitative which individuates him from others. Sophistication in clinical theory compounds the different treatment modalities now being utilized.

All treatment modalities, as well as the goals of therapy, must take into account the total capacity of the client (St. Pierre, 1969). However if therapy is to be therapy in deed, then it must generate understanding and capacity for warmth, relatedness, and love in the youthful drug abuser. Otherwise he will be doomed to the role of a drug robot. Relatedness is a powerful boast against feelings of loneliness, isolation, and mistrust. It unlocks the inner self and builds a bridge to others. "No man is an island." The youthful drug abuser has to become socialized in a community milieu which will facilitate his self-discovery and self-becoming.

If treatment is to develop the self, better adjustment means helping the abuser:

1) to overcome sensitivity and frustrations;
2) to be able to handle one's moods and emotions;
3) to develop a flexible attitude;

4) to be able to face the future and responsibility without anxiety;

5) to conquer loneliness and to see aloneness as an opportunity to deepen one's understanding of self;

6) to value persons more than things, events or functions;

7) to possess realistic ideals and constructive goals, even if they are short-ranged;

8) to seek new experiences, where outcomes are not always guaranteed;

9) to stimulate an appreciation of the ordinary aspects of life; and

10) to have a sense of commitment to something bigger than oneself.

### Is Recidivism Equivalent to Real Failure in the Strict Sense?

Statistics provide predictive clues by which to gauge adjustment in the drug abuser. Recidivism is a global term applied to a highly intricate operant agent, the human person. A type of structural analysis involving the total functioning might yield more enlightment on the degree of recidivism. In other words, what I'm suggesting is that there is no such phenomena as total failure or total success; for, even when we speak of "normal," we think in terms of degrees of variance. Therefore the therapist should investigate the following questions.

1) What is the state of the self-concept, and if it has been altered, in what direction?

2) What constructive efforts were made towards adjustment through school or employment?

3) Is the client willing to admit he has a problem?

4) What insight has the client gained into his problems?

5) How long were his attempts at abstinence?

6) Is he motivated to try abstinence again?

7) Has he appreciably altered his perception of significant others? To what extent does he depend upon them for approval?

8) Does he know what stress situations precipitate the craving for drugs?

9) If he was a pusher in the past, does he recognize the harm he is doing to others?

10) What are the attitudes and values which make him tick? Are his attitudes and values integrated?

Recidivism may be a form of testing the limits of the therapist and simultaneously a fear of giving up a known way of life for the unknown demands of society. Telson (1964) notes that addicts have been conditioned to personal rebuff and may commence therapy fully expecting this prophecy to be fulfilled.

### Pitfalls to Avoid

The youthful drug abuser has a coping problem and a low frustration-tolerance threshold. To present himself either voluntarily or involuntarily for treatment will be an emotionally-charged experience. The impact of the professional worker or the helping agency must be solid enough to offset this tension. At times therapeutic efforts may be diluted by too much stress on background questionnaires or attention to life history details rather than the individual as he exists now. Although severe addiction leads to medical complications, one can become too involved with detoxification or physical condition to the exclusion of other aspects of total functioning. "People who need other people are the luckiest people in the world . . ." This is the lesson the youthful drug abuser has not learned.

As such, equilibrium must be sought through the coordinated efforts of relevant persons and agencies. Literature is strikingly redundant with reports of group psychotherapy in the treatment of addiction. When confronted by a youthful recidivist most likely he is being treated by the very same techniques which he failed to utilize successfully the first time.

Escalating recidivism calls for more creative efforts, techniques, and therapies! Persons (1967), in studying the relationship between psychotherapy and subsequent community adjustment, found that an experimental group of 41 delinquent boys, who had received 20 weeks of therapy while incarcerated, had a low rate of recidivism when compared with the control group. Perhaps more information is needed, not on the technique of therapy, but on what makes a successful therapist or role model for delinquent boys. It is significant that most of the subjects had never experienced a satisfactory relationship with their father or father surrogate, and oftentimes the father was not a member of the family constellation.

Periodic evaluation of a treatment program should be an accepted fact; yet Dole and Warner (1967, p2000) indicate that valuable years of research have been wasted for want of systematically collected, objective data." Failure due to lack of proper evaluation means more than expensive, useless budgets, sprawling buildings, compact proposals, and static staff; it means twisted lives, those of the youthful drug abuser.

## Treatment

Statements such as, "What is the best therapy for the abuser?", or "Addicts are doomed losers" are myths which drug addiction workers must challenge. Therapy, with an unmotivated abuser or hostile community, will produce relatively negligible effects (Huey, 1971, p927). Motivation is the key to curing a drug addict. Personal equilibrium and growth must take place through a kind of tension in the client, involving and resolving the alternating desires for dependence and independence (Clark, 1958, p377).

Unless the addict desires mastery of his craving, all other steps in the therapeutic process will be built on a hollow foundation (St. Pierre, 1971, p80; Krumboltz, 1966; Baumann, 1970, p19).

Unmotivated adolescent drug abusers may act out their rebelliousness, antisocial attitudes, and defiance against "the establishment" by complete rejection of staff, schedule, and general treatment procedure (Harms, 1965, p126; Naumann and Tamerin, 1971, p84). One of the reasons for the uncooperativeness in the adolescent marijuana smoker is their lack of duress about having to relate or make it in the adult world. Their primary concern and allegiance remains in the peer group.

To choose to remain an addict or take the role and behavior of a "cured" addict remains a fundamental option for those in therapy. A cure is potent when the drug abuser initiates concrete measures towards better adjustment. However this is an arduous task for it involves two universal observations of personality change (Worchel and Byrne, 1964, p105):

1) some sort of intense affective or feeling process occurring in the individual and
2) some change in an ongoing personal relationship.

Parental support and family psychotherapy have been cited as vital factors in the therapeutic process by Caroff et al (1970), Taylor (1965, p44), Ungerlider and Brown (1969), Bender (1963, p193), and Rubin (1969, pp24-25). Multi-family counseling groups were found by Hendricks (1971) to have a more favorable impact on acceptable adjustment in participating outpatients than on male outpatients who were not exposed to this treatment intervention. Both Rubin and Gendlin challenge local communities to become therapeutic by competent and sustained emphasis on community psychology. Didactic seminars on drugs and their effects in conjunction with peer group therapy have been advocated by Katz (1970, p57). Klein and Phillips (1968) indicated group therapy for addicts is meaningful when conducted by ex-addicts, or where there is a strong group leader who enforces peer standards. Huey (1971, p927), asserts that an ex-addict is uniquely qualified for the task of therapeutic agents "because of his addiction experiences and his own ability to manipulate, he is not likely to be manipulated," an assertion supported by Egan (1966, p505).

Peer and parental sharing in the therapeutic process has been stressed by Herzog (1970). According to Guarino and Shapiro (1971, pp370-371): "It is necessary to motivate young addicts particularly during detoxification with series of 'rap sessions' involving motivational, cultural, and educational sessions as well as an introduction to self-help adolescent groups in the community." Perhaps the greatest problem posed in a therapy session between addicts and ex-addicts, or between parents and children, is to achieve growth-promoting communication. Genuine communication must include rapport and seriousness of intention, good listening skills, and cognizance of verbal and nonverbal clues. One must listen to the lips as well as to the heart of the other — to what is spoken and to what is unspoken.

Other mediums of therapy* which might assist the youthful drug abuser in a new self-becoming include these ten things:

1) Residential facilities, which aim to create a family atmosphere, have been cited as a primary need, especially in neighborhoods or situations which tend to decompensate rather than build a person. These models of family life are means to teach youngsters mutual respect and sharing. In such facilities, concern must be tempered by a structure which facilitates the youthful drug abuser's knowledge of correct roles and expectations. Adolescents do not like to be left dangling, nor do they appreciate being treated as children, misfits or "sick people." Resourceful and tactful adults are the best people to teach youth responsibility.
2) Halfway houses are springing up rapidly. They can supplement other forms of therapy by offering channels for self-appraisal and group feedback if viewed as extended care facilities rather than custodial or domiciliary institutions. If they are to span the gap between the abuser and the community, they must consistently proffer the image of each for study and review. The long-range effects of halfway houses can only be inferred for indepth study on their potential and accomplishments is almost totally nonexistent to date; some impressive accomplishments have been recorded by Synanon, Daytop, and The Village Haven. Both Synanon and Daytop (Yablonsky, 1965 and Shelby, 1966) insist on a "gut-level" therapy, reality oriented, not a psychoanalytic ploy. However, Fisher (1965, p195) shares with us an astute observation that, for the inpatient,

* Recommended: "Some Considerations in the Treatment of Non-Narcotic Drug Abusers."

one of the very real hindrances to treatment might well be his past experience in a correctional institution or a government hospital. If the confinement was not voluntary, real negativeness and embitterment may overwhelm him. With the residential youthful drug abuser, this presents an added problem for negativeness or is contagious!

3) Support for student-operated counseling and crisis centers as advisory rather than formal treatment centers has been given consideration by McCarthy and Berman (1971) and Osnos (1965). Their "hot line" function seems to have at least some short-range therapeutic effects.

4) Audiovisual aids, such as films and tapes, may be cathartic stimuli in assisting the drug abuser to express his feelings about his way of life, his goals, and his expectations. This type of educational rehabilitation has been described by Katz (1970, p 57).

5) In order to offset overfocusing on problem behavior, orientation to the local community and the larger society may lead to new perspectives through group discussion on a current events forum. Taylor (1965, p 44) calls attention to the addict who has become "quite adept at mobilizing resources in his own behalf." Addiction is not cured by turning in on oneself but by a persistent answering of the needs of one's community. Forgetfulness of self, including one's problems and hang-ups through a serving capacity, may be the best adjunct to therapy. Behavior modification techniques can monitor one's choices and responses; yet only self-investment in responsible tasks, projects or helping relationships can lead to a therapeutic awareness of existential freedom. Essentially any form of group encounter which remains solely on the level of rapping will not have profound or prolonged influence on the abuser. Writing in support of behavior therapy are Yates (1970), Wolpe and Lazarus (1966), Ayllon and Azrin (1968), Wolpe, Satter and Reyna (1964), and Krasner and Ullman (1965). It is an experimental method applied to a problem behavior in order to program a positive empirical outcome on behavior change.

6) From my own discussions with drug addicts, a recurring complaint is that they get nothing out of group therapy, encounter groups, or marathon groups. Maybe what they are really saying is that they are submerged in the group. While group therapy may help a client to experience his level of adjustment with a reference group, individual and family counseling seem necessary to permit the real "moi" of the addict to surface. Many adolescents begin taking drugs simply because they feel no one really understands or cares for them. Age is no criteria on which to judge suitability to work with youth—empathy and good judgment are! Only a sound therapeutic relationship can vanquish the feelings of panic, guilt, worthlessness, and hopelessness experienced by drug abusers (Torda, 1968 and Toll, 1970).

7) Role playing as well as the psychodrama deal with interpersonal relations and private worlds. Through the process of enactment, the client is enabled to confront himself, his conflicts, and to meet those persons he considers influential in his life. Gendlin (1968, p 68) suggests: "We behave according to the roles we are placed in." Is the addict acting out an expected role within his community? Self-confrontation via video tape has been found effective in reducing pathology and discrepancy between the self-concept, the ideal self, and the public self (Boyd and Sisney, 1967).

8) A case report involving aversive conditioning (electric shocks) with a 21-year-old college senior has been described in the literature by Lesser (1967, pp 251-252). Some ten months after the termination of treatment, the client had not taken hard drugs. Injected into this success story are some significant factors: the client was not strongly addicted to narcotics, and was motivated even to the point of being self-referred.

9) Goldburgh (1968), Kraft (1968), and Baumann (1970), all reported successful results using hypnotherapy with drug abusers under 21 years of age. "Hallucinating hallucinogens" (Baumann, 1970, p18) as a form of therapy has resulted in some promising trends if the recipient of such therapy was motivated and had been a user of LSD, amphetamines, and barbiturates. However marijuana users appeared to be unmotivated because they stated the drug was only legally dangerous.

10) Therapeutic recreation also augments adjustment through stress on balanced living. According to Young (1964, p23), the therapeutic aspect is helping the addict achieve socially constructive and acceptable ways of expressing himself in leisure time actives within his own community.

## Conclusions

If the youthful drug abuser is to conquer his problem, therapy must have two specific goals. The first is creation of an identity with which he feels comfortable or, to phrase it differently, the ability to grasp his uniqueness as a person. The youthful drug abuser has not existed enough years to really live life — he quit before he really got started! Therapy must be a process of building the human person, not rehabilitating swollen veins, undernourished bodies, or waxed wills. It must be humanistic, total and ongoing; such therapy starts with an attitude of real concern and develops to an attitude of uncompromising rapport, even long after the abuser's official case file has been closed. But nothing can be accomplished without the client's willing it!

Secondly, a primary source of the youthful drug abuser's difficulty can be laid to poor interpersonal skills. Therefore socialization or the development of artful and skillful interpersonal relations is absolutely necessary if the client is to continue to develop. The process of therapy cannot be cold and mechanistic; it must be a person-to-person encounter. If therapy remains on the level of external control and confinement, nothing more than a state of induced vegetation exists — therapy has not even begun! Realistic therapy with the youthful drug abuser should aim for nominal functioning, not maximum actualization of the person. Therapy must be reality-oriented by helping the youthful drug abuser to accept the fact that there will be no

red carpets or laurels because he gets "cured". He must be realistic enough to know he will still have to prove himself for he is bound to encounter misunderstanding and prejudice.

To assist him in his adjustment to the larger society a real "will-to meaning" must be created. Rather than program his therapy, can you ignite and elicit in him a real desire to assume his role in society? Inner conviction that one can "make it" or "stay clean" is the needed attitude which yields stamina and fruition.

There is no right therapy or miracle formula for dealing with drug abusers. Cure must be the joint venture of a motivated abuser, a loving family, a concerned community, and truly dedicated professionals. Since the therapist has the most intimate and prolonged contacts, especially with residential abusers, if his attitude reinforces defeat and gloom, the abuser will respond similarly. Sometimes the communication of hopeful expectations can be accomplished with good effects by placing demands on the patient, the implication being that the patient has the capacity to fulfill them (Stotland, 1969, p213). The abuser has a severe adjustment problem but not an insurmountable one. Then too the therapist should not expect or seek his client's gratitude. Improved ego functioning on the part of the youthful drug abuser may make him hesitant to express feelings which demean his new feelings of self-worth.

The family and community must assume their rightful places as therapeutic agents. Drugs filled a void, now they must fill the void.

Therapy must not grind to a halt once detoxification has been accomplished. It must incorporate intensive follow-up and aftercare. Even the shortage of trained professionals can be alleviated to some extent by tapping the energy and goodwill of ex-addicts. A type of Narcotics Anonymous might be the supportive aftercare therapy needed to help a wavering abuser make it.

The process of treatment involves much pain, work, struggle, courage, self-searching, and commitment on the part of the abuser, his family, community, and the professional worker.

#### References

A complete listing of the 76 references used with this article—as well as answers to related questions—may be secured by writing to the author at P. O. Box 3235, Baltimore, Maryland 21228.

# DRUG ABUSE COUNCIL

Four major private foundations have established a national Drug Abuse Council as an independent source of information, policy evaluation, and research funding in the field of drug abuse. The Council will be funded at from $10 million to $15 million over the next five years.

Chairman Bethuel M. Webster said it would seek "to bring a calm voice into the confused national discussion on behalf of a frightened and baffled public."

He said the aim of the Council will be to become "a pace-setting agency to which the interested citizen and private and government bodies concerned with drug abuse policies and programs can turn to find out what is working and what is likely to work."

The four foundations funding the project initially are the Ford Foundation, Carnegie Corporation of New York, Commonwealth Fund, and the Henry J. Kaiser Family Foundation. The Council will consist of 15 leading representatives of various sectors of American life.

Mr. Webster said: "The most important reason for confusion, division, and ignorance in the drug abuse field is the lack of leadership in gathering and evaluating information and focusing such knowledge to develop policies. Hundreds of organizations are going in different directions on drug abuse education, treatment, or control with inadequate information, and unsatisfactory measurement and communication of results."

The Council's immediate agenda includes 1) development of criteria for evaluation of drug abuse treatment and rehabilitation procedures; 2) evaluation of state and federal laws and regulations on dangerous drugs, penalties for possession, and their effects on the community; 3) assessment of the many approaches to information-dissemination and education about dangerous drugs; 4) funding of biomedical research to learn more about the effects of heroin and methadone on the human body; and 5) investigation of the market for dangerous drugs and of efforts at international control of drug traffic.

# TREATMENT OF OPIATE OVERDOSAGE

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## Introduction

There is evidence that the number of deaths due to the illicit use of opiates is increasing. In the period 1951 to 1955, 6% of drug-related deaths known to the office of the Chief Medical Examiner of the State of Maryland were reported as "due to opiates and narcotics (unspecified)." In the period 1961 to 1966, this increased to 12.6% of drug deaths from all causes. The absolute number of drug deaths during this period increased as well.[1] A condition caused by opiate abuse — opiate overdosage — is now being encountered more and more frequently, most particularly in the Emergency Service of urban hospitals.

## Diagnosis of Opiate Overdose

The correct and rapid diagnosis of a patient overcome by opiates depends to a great degree upon the suspicions of the examining physician. The diagnostic task is made difficult because of the possible presence of other drugs taken during the same period and because of the rather wide variety of individuals who are brought for treatment. There is frequently little history given as the patients are often dropped rather unceremoniously at the entrance of the hospital's Emergency Service.

Scars on the arms (tracks) due to repeated injections of opiates may or may not be present. Patients can overdose when they are just beginning to use opiates intravenously, when they are ceremoniously at the entrance of the hospital's taking the opiate orally, or while sniffing opiates. In all of these instances, tracks may not be present. Even when tracks are seen it is very possible that the patient's depressed state is due to some other cause besides opiates.

The classical triad of coma, pinpoint pupils, and depressed respirations is not restricted to patients who are overdosed with opiates. This clinical constellation can be seen in patients overdosed with a variety of sedative-hypnotic drugs such as phenobarbital and chloral hydrate. Patients brought for treatment after opiate use may be stuporous or even comatose but without significant respiratory depression. Barbiturate overdosage, in particular, must be considered because of the frequency with which barbiturate overdosage is seen in adults and because barbiturates, like all the sedative-hypnotics, except perhaps glutethimide, can cause small pupils.[2] All sedative-hypnotics can produce respiratory depression if large enough doses are taken.

Care must be taken that no other cause of coma is being overlooked. The opiate user functions in a violent environment where he is prone to injuries of various kinds. Other causes of stupor and coma such as renal, hepatic, pulmonary, or endocrine disease, as well as cardiovascular problems, must also be considered.

## Treatment of Opiate Overdose

Death from opiate overdose is most often due to depression of the respiratory center with resultant anoxia. Where the depression is not sufficient to cause death, other pulmonary problems such as pneumonia secondary to bacterial infection and/or aspiration, atelectasis, pulmonary edema, or some combination of all of these may be seen. It is thus imperative that the patient be adequately oxygenated and his respiratory system be protected from aspiration. The hasty use of narcotic antagonists, nalorphine hydrochloride (*Nalline*), or levallorphan tartrate (*Lorfan*) without first looking for the presence of pulmonary problems can be very hazardous to the patient, who may then be difficult to manage and keep under treatment.

When the patient suffering from opiate overdose is first brought for treatment, his upper airway should be carefully examined for possible obstruction, particularly by vomitus. If ineffec-

tive ventilation is noted, respiratory assistance with a ventilating bag and mask should be immediately provided. No time should be lost while awaiting the arrival of a trained individual to pass an endotracheal tube. Oxygen may be given through the mask. There is no need to give an opiate antagonist immediately if the patient is being adequately ventilated.

When an opiate antagonist is administered to the patient very early in treatment, the patient can be put at a decided disadvantage.

Case #1—A 20-year-old male was brought to the Emergency Service comatose with depressed respirations and pinpoint pupils. Because of the slow respiratory rate, the patient was given five milligrams of intravenous nalorphine hydrochloride (*Nalline*). Within two minutes he was wide awake and, on perceiving that he was in a hospital, the patient jumped off a stretcher and ran out the door. No information had been collected about this patient and only a very cursory examination of his lungs had been performed.

While at first glance such an occurence may be humorous, it is obvious that the hazards to this patient are very real. The effective duration of action of nalorphine hydrochloride (*Nalline*) is one to four hours. The effective duration of action of heroin is about eight hours, and that of methadone 24 to 36 hours and even longer. The patient treated with intravenous nalorphine hydrochloride (*Nalline*) may respond immediately, as the patient above, but within a few hours again may become very depressed as the antagonist effect on the respiratory center wears off and the depressant effect of the original opiate reoccurs. This is a particular hazard with methadone because of its long duration of action. An antagonist, nalorphine hydrochloride (*Nalline*), may have to be administered three or four times during the 24 hours following methadone overdosage.

Waking a comatose patient with respiratory depression by using nalorphine hydrochloride is very dramatic to observe, but can give medical staff and the patient a false sense of security.

Even if a patient is kept in Emergency Service after being initially treated with an opiate antagonist, he must be watched by individuals knowledgeable about this problem.

Case #2 — A 20-year-old man was brought to Emergency Service in an unconscious state and with depressed respirations. The patient was treated with five milligrams of intravenous nalorphine hydrochloride (*Nalline*) and awoke immediately. Respirations returned to normal at 18 per minute. The patient was kept in Emergency Service for observation. Three hours later, the patient was noted to be "asleep" with respirations of ten per minute. Approximately one hour after that, the patient was found to be cold, clammy, and anoxic with respirations only four per minute. Only very energetic resuscitation measures saved this patient from death from respiratory depression. Here there was insufficient regard for a possible return to a depressed state following successful use of an antagonist.

A second hazard associated with the use of nalorphine hydrochloride (*Nalline*) is related to its ability to itself cause respiratory depression. The action of nalorphine hydrochloride (*Nalline*) on the respiratory center of a patient who is not depressed with opiates is the exact reverse of its effect upon a patient who is. In a patient suffering from respiratory depression secondary to a sedative-hypnotic, the addition of nalorphine hydrochloride (*Nalline*) can add to the patient's respiratory depression. While no deaths have been reported in the United States due to nalorphine hydrochloride (*Nalline*) overdosage alone, there is a very real theoretical possibility that death could result from nalorphine hydrochloride (*Nalline*) in conjunction with another non-opiate respiratory depressant.[3]

A third problem associated with the use of nalorphine hydrochloride (*Nalline*) is its effect as an emetic. It can produce very active vomiting and, in a patient who is unable to protect his respiratory system, this can result in a massive aspiration.

For these reasons, the following steps are recommended in handling the overdosed opiate user:

1) Immediately upon coming into medical treatment, the depressed patient's upper airway should be carefully examined and cleared and, when necessary, artificial ventilation with a bag and mask should be begun immediately. Oxygen should be administered through the mask.

2) Blood gases should be drawn and consultation with an enesthesiologist should be obtained. If the patient's unassisted ventilation is felt to be inadequate, then intubation should be performed, the endotracheal tube cuff blown up, and the patient placed on a respirator.

3) As soon as the patient's immediate respiratory problems have been attended to, he should be fully examined and an X-ray of the chest should be obtained.

4) Intravenous infusion should be begun to allow easy administration of drugs.

5) Blood and urine for possible *later* toxicological determination should be obtained. A satisfactory clinical course often makes such determinations unnecessary.

6) When pneumonia is present treatment should be initiated immediately utilizing antibiotics and steroids if aspiration is suspected. If pulmonary edema is observed, then appropriate therapy with diuretics, IPPB, rotating tourniquets, and diuretics should be begun.

If, on the initial examination, the patient's respiratory exchange is adequate and intubation is deemed unnecessary, then the patient should be placed where he can be very carefully observed and where slowing of respirations will be immediately noticed.

If anesthesia assistance is not readily available, then an antagonist may have to be used early in the patient's clinical course. It should be used however only to treat respiratory depression. There is no need to give an opiate antagonist to a patient who is either stuporous or comatose but who is breathing adequately. Such patients should be carefully observed.

On occasion, the administration of nalorphine hydrochloride (*Nalline*) to a patient overdosed with an opiate will increase respirations but the patient may not immediately regain consciousness. There is no need here to repeat the injection of the opiate antagonist since the reason for giving the drug, ie, to increase the respiratory rate, has been accomplished. It is well to turn the patient on his side before the antagonist is administered to protect him against vomiting, and some type of protective restraint should be placed over the patient in case he should wake up, become frightened, and try to run away before his situation can be explained.

The usual dose of nalorphine hydrochloride (*Nalline*) of 0.1 milligram per kilogram and of levallorphan tartrate (*Lorphan*) 0.02 milligrams per kilogram intravenously. Either drug may be used. This dose may be repeated within 20 to 30 minutes if respiratory depression does not improve. If there is no response after this, the diagnosis of opiate overdose is probably in error.

If the patient's respirations have improved in response to the first injection, but are not yet felt to be adequate, the antagonist may be given a second time in five minutes and again in ten minutes.[4]

When the patient is aroused by the use of an antagonist, he should be kept under observation because of the possible development of complications. A 24-hour observation period has been advised.[5]

If a patient should be severely addicted to opiates, the administration of an opiate antagonist may precipitate an immediate withdrawal syndrome which will last a few hours. No attempt should be made to alleviate the patient's symptoms by readministering opiates because very large doses would be required, and the patient would be in danger of reoverdosing from the newly administered opiates after nalorphine hydrochloride (*Nalline*) has dissipated.

Naloxone hydrochloride (*Narcan*), because of its actions, may well become the drug of choice where an opiate antagonist is required. This drug will immediately reverse the respiratory depressant effects of the opiates but does not itself have respiratory depressant effects. It will thus not cause increased respiratory depression in patients who have overdosed with other drugs besides opiates. This drug is still considered investigational however, and has not been released for general use as yet.

Note: Naloxone hydrochloride (*Narcan*) was released for general use in Novermber 1971. Its use was recently discussed in The Medical Letter 14:1, January 7, 1972.

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## Pharmacies Help Combat Drug Abuse

Some 168 Maryland pharmacies have agreed to serve as drug abuse information centers. So says Morris Walman of the Drug Abuse Administration.

A poster will be displayed at each participating store indicating its involvement. A supply of free pamphlets will be placed in a prominent position near the drug counter.

Additionally, each pharmacy will have lists showing where referrals can be made. Mr. Walman hopes to enlist at least 500 of Maryland's 800 pharmacies in the program.

# EXTENT OF THE DRUG ABUSE PROBLEM

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Since its inception, a primary goal of the Drug Abuse Administration of the Maryland Department of Health and Mental Hygiene has been to determine the extent of the drug abuse problem in Maryland. The Administration was so mandated by Section 5(a) of Executive Order Number 1, of January 22, 1971, which states that the "Administration shall: Survey and analyze the State's needs . . ." and by Section 5(g) which reads that the Administration shall ". . . gather information and maintain statistical and other records relating to drug abusers and drug abuse in the State."

In order to meet these directives, the Drug Abuse Administration is gathering data that will provide a profile of drug abuse in the State. The following types of information have been examined:

1) overdose deaths,
2) serum hepatitis cases,
3) narcotic abuse cases reported to the Narcotics Addict Register, and
4) arrest records.

All records of drug-related deaths that are available at the medical examiner's office have been abstracted for the calendar year 1971.

Information reported by physicians throughout the State to the Division of Communicable Diseases concerning serum hepatitis cases has been examined for the years 1970 and 1971. A weekly reporting system, which separates the serum hepatitis cases from the infectious type, has been instituted. Improved reporting from all physicians to the Division of Communicable Diseases would be an invaluable aid in this data collection effort.

"Serum hepatitis is probably the most common disease in the addict population. This disease may be found in 25% to 40% of 'mainline' heroin addicts who present with a medical problem. Two to 3% of addicts with active hepatitis have hepatitis-associated antigen (HAA, Australia antigen) in their blood, as compared with 0.1% of normal volunteers — a 20 to 30-fold increase (New Eng J Med 285: 40-48, 1971 CPC). A study from the Nassau County, New York Health Department (Amer J Med 50: 313-316, 1971) showed that of the 162 cases of serum hepatitis reported between 1967-1969, 107 (66%) were in narcotic users. Further, in the 13 to 29 year age group, of the 112 cases of hepatitis, 106 (95%) were in narcotic users."[1]

The following table gives the number of reported serum hepatitis cases in Maryland for the calendar years 1970 and 1971. Reporting of this kind is generally very incomplete, with many physicians not sending in their reports. Therefore these figures are probably underestimations. Also the larger figures for 1971 may be due to better reporting rather than an increase in the number of cases. Nevertheless, the 16% increase of reported cases in 1971 over 1970 bears further examination.

**Serum Hepatitis Cases Reported to Division of Communicable Diseases, Maryland Department of Health and Mental Hygiene, 1970 and 1971, by Drug Abuse Administration Region**

| | 1970 | 1971 |
|---|---|---|
| Region I | 6 | 10 |
| Region II | 25 | 20 |
| Region III | 4 | 7 |
| Region IV | 7 | 12 |
| Region V | 18 | 26 |
| Region VI | 12 | 18 |
| Region VII | 104 | 114 |
| Total | **176** | **207** |

Treatment programs for the narcotic addict, as well as law enforcement and correction agencies, report information on each patient to the Narcotics Addict Register. This Register has been active for more than a year and is beginning to provide valuable information.

A mail survey of all police departments and sheriffs' offices in the State was conducted dur-

ing January 1971; 96% of the sheriffs and 94% of the police departments responded.

Unduplicated arrest information was requested so that in overlapping jurisdictions each person would be counted only one time. The information will be tabulated according to the region in which the arrest occurred and will be divided into the following categories:

1) marijuana,
2) opium and synthetic narcotics,
3) other dangerous and/or hallucinogenic drugs,
4) paraphernalia and false prescriptions, and
5) common nuisance and others.

Of course, this breakdown provides information on the abuse of drugs other than narcotics.

A prevalence study of drug abuse among junior high and high school students throughout the State is also under consideration. Such a study would supply much needed information regarding the extent of the drug abuse problem in Maryland.

Knowledge of the extent of the drug abuse problem is essential to the intelligent planning of programs. Additionally, repeated prevalence studies over a given period of time should indicate changes, either up or down, and are an invaluable aid in evaluating the adequacy of the State's programs in relation to the total problem.

## Evaluation of Programs

Every State agency is responsible to the citizens for an evaluation of its activities and programs. The Drug Abuse Administration has taken steps toward the development of such an evaluation capability.

The first move in this direction was the implementation of a monthly reporting system, which began in December 1971. Each program is asked to report patient movement on a monthly basis. From these data the total number of persons in treatment in each type of modality is obtained. Data on new admissions, readmissions, and discharges will also become available.

Fiscal data, reported by the Drug Abuse Administration funded programs, will be meshed with the patient figures in order to generate the costs of various types of treatment modalities.

The second step in the overall plan will be gathering of certain types of information about each patient in a treatment program. Work in this area has just been started with a consultative meeting of Drug Abuse Administration members and systems analysts who are working with Jerome Jaffe, MD, of the President's Special Action Office for Drug Abuse Prevention. Close cooperation between these agencies and each of the treatment programs is anticipated before any decisions are made regarding the data elements to be collected. Nevertheless, information that can be utilized for evaluating the effectiveness of treatment programs will be high on the list of priorities.

These plans will partially meet the urgent needs of the Drug Abuse Administration for some measures of effort, cost, and effectiveness of treatment programs. Planning in this area continues at the Drug Abuse Administration and it is anticipated that shortly there will be a full range of evaluative studies to provide data about all drug abuse programs.

## Services to Physicians

Perhaps the most helpful information for physicians would be a rundown of Drug Abuse Administration services for practicing physicians in the State. Maryland has been divided into seven drug abuse regions, each with its own services and directors. Within each region, community groups supplement services provided by the Drug Abuse Administration. A rundown on these regions follows.

| REGION I | Regional Director |
|---|---|
| Caroline County<br>Cecil County<br>Dorchester County<br>Kent County<br>Queen Anne's County<br>Somerset County<br>Talbot County<br>Wicomico County<br>Worcester County | Mrs. Betty Nelson<br>1 Plaza East<br>P.O. Box 301<br>Salisbury, Maryland 21801<br>Ph: 749-1133 |

**Types of Services:** urine surveillance, crisis intervention, counseling, detoxification, methadone maintenance.

| REGION II | Regional Director |
|---|---|
| Baltimore County<br>Carroll County<br>Harford County | Derek von Roemer, PhD<br>Baltimore County Health Dept.<br>105 W. Chesapeake Avenue<br>Towson, Maryland 21204<br>Ph: 494-2731<br>**District Coordinator**<br>William Lee<br>5012 Dickey Hill Road<br>Baltimore, Maryland 21207<br>Ph: 448-9259 |

**Types of Services:** recreational activities, urine surveillance, training and community education, crisis intervention, counseling, detoxification, methadone maintenance.

| REGION III | Regional Director |
|---|---|
| Allegany County<br>Frederick County<br>Garrett County<br>Washington County | James Reagan<br>Coordinating & Counseling Center<br>Suite 208 |

Antietam Professional Bldg.
Mulberry & Antietam Streets
Hagerstown, Maryland 21740
Ph: 797-8300

**District Coordinator**
Peter Charuhas
26 North Centre Street
Cumberland, Maryland 21502
Ph: 724-8602 - 8608

**Types of Services:** training & community education, crisis intervention, counseling.

| REGION IV | Regional Director |
|---|---|
| Anne Arundel County | Thomas Crane |
| Calvert County | 12-J Crain Highway |
| Charles County | Glen Burnie, Maryland 21061 |
| St. Mary's County | Ph: 768-7446 - 7447 |

**Types of Services:** urine surveillance, crisis intervention, counseling, detoxification, methadone maintenance.

| REGION V | Regional Director |
|---|---|
| Howard County | Mrs. Shirley Daniels |
| Montgomery County | 230 North Washington Strtet |
| | Rockville, Maryland 20850 |
| | Ph: 762-7700, ext 56 |

**District Coordinator**
Julius Margolis
230 North Washington Street
Rockville, Maryland 20850
Ph: 762-7700, ext 56

**Types of Services:** crisis intervention, counseling.

| REGION VI | Regional Director |
|---|---|
| Prince George's County | Joseph L. Amico |
| | 405 Crane Highway |
| | Upper Marlboro, Maryland 20870 |
| | Ph: 249-7200 |

**Types of Services:** urine surveillance, training and community education, detoxification, crisis intervention, counseling, methadone maintenance

| REGION VII | Regional Director |
|---|---|
| Baltimore City | Robert Costello |
| | 202 East 25th Street |
| | Baltimore, Maryland 21218 |
| | Ph: 383-5590 |

**District Coordinators**
Mrs. Naomi H. Evans, Northwest
Mrs. Elaine Murphy, Southwest
Mrs. Laura McCall, Southeast
202 East 25th Street
Baltimore, Maryland 21218
Ph: 383-5590

**Types of Services:** urine surveillance, research, training and community education, crisis intervention, counseling, residential, detoxification, methadone maintenance.

The regional directors are the official representatives of the Drug Abuse Administration in strategic areas around the State.

The offices of the Regional Directors can:

1) assist in placing patients in State hospitals on an inpatient basis,
2) provide information on all drug treatment programs in the region, and
3) supply copies of the "Directory of Resources for Drug Abusers and their Families."

#### References

1. Maryland State Department of Health and Mental Hygiene, Division of Communicable Diseases. Infectious Disease Complications of Narcotic Addiction. July 27, 1971.

## HELP FOR HEROIN ADDICTS

In a story from the University of Chicago reported in the AMA's *Audio News Journal,* a psychiatrist predicted his approach to the treatment of heroin addiction will help control the spread of this disease.

Patrick H. Hughes, MD, said his approach was borrowed directly from existing methods of venereal disease control. He discovered after a year of study that heroin addiction spreads like an infectious disease. Prior to that time it was thought addiction spread like mental illness. A certain neighborhood could be expected to produce so many schizophrenics a year. Then he noticed that addiction did not follow such a predictable pattern.

After close study he noted that any neighborhood containing a number of drug addicts also had a highly structured drug distribution network, stable socially and geographically This he attributed to the addict's need for a continuing drug supply.

The key to his approach is epidemiological field teams located at these heroin distribution sites which try to remove addicts from the community through treatment outreach programs. He reported he had no trouble from drug pushers once they trusted him, because they realized they might need his treatment at some time in the future themselves. A very important member of the team is an exmember of the drug community now in treatment whom the addicts trust.

After studying one neighborhood that was undergoing a sudden upsurge in the number of heroin addicts, he set up a clinic there. At the present time 44 addicts are in treatment, with others being admitted at a rate of five per week.

"We feel certain we have already cut down the spread of heroin addiction," Dr. Hughes said, "and I think in the near future we will demonstrate we are able to control this epidemic."

Dr. Hughes is also Director of the Epidemiology Section of the Illinois Drug Abuse Program.

# DRUG ABUSE NEWS BRIEFS

## Sinai Expands Drug Detoxification Program

Sinai Hospital of Baltimore has expanded its Drug Dependency Program to include drug detoxification and abstinence. It has also initiated a 90-day detoxification schedule; most schedules run from 20 to 30 days.

The new procedures give the hospital a fully comprehensive drug treatment program: methadone maintenance, accommodating over 100 people; and detoxification and abstinence, which can handle from 20 to 30 patients each.

"The longer detoxification period is an attempt to provide a more effective method to wean people from opiates," says Fred Goldman, program administrator. He added: "Some authorities feel that the shorter period is largely unsuccessful because the body doesn't have enough time to adjust to withdrawal."

Addicts who have achieved total abstinence from opiates will have the opportunity to go on to the new abstinence program. Patients come here for individual or group counseling as often as necessary. They must also provide the hospital with urine specimens three times a week.

Sinai has also lowered eligibility requirements. Only one year of addiction (instead of two) is now required. Prospective patients may make their own appointments or be referred by a physician or agency.

Sinai's comprehensive drug dependency program is part of the original Northwest Drug Alert, a community drug treatment effort started a year ago through funding by the Associated Jewish Charities and the United Fund of Central Maryland. The present concept of broader treatment was made possible when the state took over funding through the State Drug Abuse Administration.

## Alternative Pursuits Versus Drug Abuse

The National Institute of Mental Health is exploring a new approach in the fight against drug abuse—psychological substitutes to drug addiction.

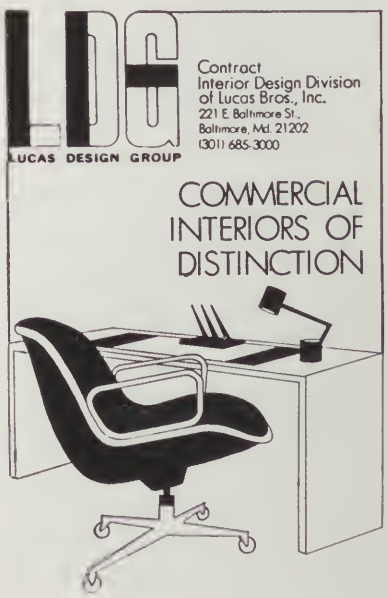
The project, called "Alternative Pursuits for America's Third Century," will seek those substitutes by encouraging communities to devise innovative programs and activities to turn people away from drugs by fulfilling some of the needs that drive them to drugs.

"We hope to focus the skills, energy, and ideas of people all over the country on discovering innovative pursuits and resources to meet human needs and make life more rewarding," said Bertram S. Brown, MD, NIMH director and special assistant to the secretary for Drug Abuse Prevention.

"We've all talked about alternatives as important to prevention," said Dr. Brown, "but very little has been done to identify those alternatives. We'd like to start people really thinking about them. Drug abuse basically springs from boredom, alienation, and a sense of inability to cope with life. It is obvious that efforts to combat drug abuse are futile unless we expand opportunities for people to find satisfaction and meaning in today's world."

NIMH plans to stimulate ideas and designs for these activities and organize a national collaboration to give communities experience in determining alternatives. A conference will be held in June at Warner Hot Springs, California.

Information about participation in this project can be obtained from Alternative Pursuits, P. O. Box 861, Del Mar, Calif. 92014.



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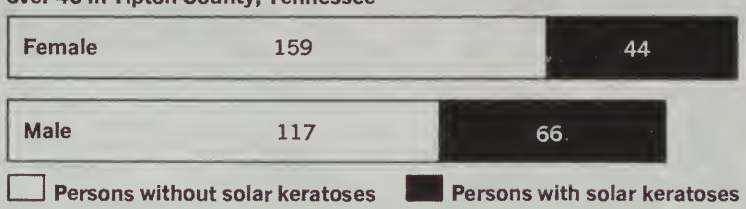
# What it means to live and work in Tipton County, Tennessee

## Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee**




*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



## Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

## Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

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**Contraindications:** Patients with known hypersensitivity to any of its components.
**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.
**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.
**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.
**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.
**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.
Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

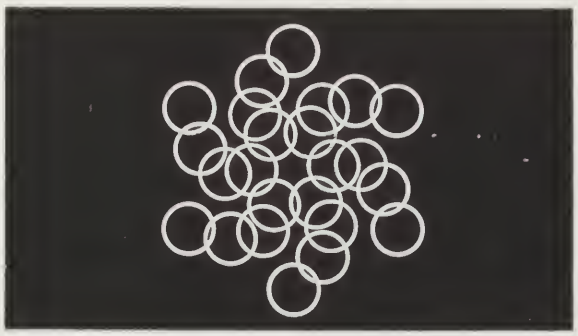
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland



# ALCOHOLISM PREVALENCE IN MARYLAND PENITENTIARY RECEPTION CENTER

**STEVE HASH**
**Program Consultant**
**Division of Alcoholism Control**
**Dept. of Health and Mental Hygiene**
**State of Maryland**
**Baltimore**

One hundred and four inmates at the Reception Center of the Maryland Penitentiary were interviewed between November 17, 1971 and December 7, 1971. The purpose of the interviews was to determine the prevalence of alcoholism among inmates just beginning their sentences.

The Michigan Alcoholism Screening Test (MAST) was administered to each of these inmates. This test, devised by the University of Michigan at Ann Arbor, provides a consistent, quantifiable, structural interview instrument for the identification of alcoholics. It can be easily and rapidly administered by both professionals and nonprofessionals. Many of MAST's 25 yes-no questions have been used by other investigators in surveys of alcoholism. MAST has been validated by the University of Michigan.

Some of the questions are sufficiently neutral that persons reluctant to see themselves as problem drinkers may reveal their alcoholic affliction. Questions related to amounts of alcohol consumed were not used because of the vague responses they evoke. Where MAST is used for screening purposes, clinical confirmation may occasionally be required.

The following is a summary of the test results:

1) One inmate falsified himself by stating that he had never taken a drink. A prior record from Patuxent Institution showed that he admitted to heavy drinking for a number of years and had delirium tremens on one occasion.
2) One inmate complained of back pain after answering the first two questions and returned to his quarters. His answer to the question concerning "blackouts" was affirmative.
3) The remaining 102 inmates showed the following statistics in accordance with the scoring method established for MAST:
   40.2% were not alcoholic
   5.9% are suggestive of being alcoholic
   53.9% are alcoholic
4) Further statistics and explanation are included in the accompanying table.

## Method For Testing

MAST was administered on a one-to-one basis in a cubicle where sufficient privacy was afforded enabling the inmate to feel free to participate without being overheard. Selection of the inmates to be interviewed was random with only name and prison number available to the interviewer prior to selection.

An explanation was given to each inmate interviewed that the interviewer was not a part of the penal system, did not have the inmate's prison records, would not enter any of the information obtained during the interview into the inmate's prison records, and was taking a survey for the Division of Alcoholism Control. The inmate was asked to furnish the personal data listed on the cover sheet of MAST. Each MAST question was then verbally asked and explanations offered as required. Answers were recorded by the in-

**Table 1: Alcohol Related Characteristics Experienced by Inmates**

| Characteristics Experienced | Percentage by Age Groups | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 17 - 18 | 19 - 20 | 21 - 22 | 23 - 24 | 25 - 29 | 30 - 34 | 35 - 39 | 40 - 44 | 45 - 49 | 50 & Over | Total |
| Blackouts | 30.8 | 47.2 | 53.9 | 45.5 | 38.4 | 62.5 | 33.3 | 42.9 | 50.0 | 50.0 | 44.1% |
| Fights | 30.8 | 53.1 | 69.3 | 63.7 | 57.6 | 50.0 | 33.3 | 42.9 | 50.0 | 50.0 | 51.9% |
| Work Problems | 7.7 | 11.8 | 38.5 | 18.2 | 19.2 | 25.0 | 33.3 | 28.6 | 0 | 50.0 | 20.6% |
| Delirium Tremen (DT'S) | 0 | 11.8 | 23.1 | 18.2 | 19.2 | 12.5 | 16.6 | 28.6 | 0 | 50.0 | 15.7% |
| Hospitalized | 0 | 11.8 | 15.4 | 0 | 19.2 | 25.0 | 16.6 | 14.3 | 25.0 | 0 | 12.7% |
| Arrested, Behavior | 46.2 | 41.3 | 61.6 | 45.5 | 38.4 | 37.5 | 33.3 | 42.9 | 25.0 | 50.0 | 43.1% |
| Arrested, Driving | 0 | 0 | 0 | 0 | 4.8 | 12.5 | 33.3 | 28.6 | 25.0 | 0 | 6.9% |
| No. of Inmates | 13 | 17 | 13 | 11 | 21 | 8 | 6 | 7 | 4 | 2 | 102 |
| No. of Alcoholics | 6 | 9 | 7 | 7 | 10 | 6 | 3 | 4 | 2 | 1 | 55 |
| No. Suggestive Alcoh. | 0 | 4 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| Non-Alcoholics | 7 | 4 | 5 | 3 | 11 | 2 | 3 | 3 | 2 | 1 | 41 |

Explanatory Notes:

**Characteristics Experienced** — The listed items are related to affirmative answers by inmates to specific questions on the MAST questionnaire: 1) blackouts; 2) fights; 3) work problems (An affirmative answer to any one of three questions indicated work problems for the inmate); 4) delirium tremens (DT's); 5) hospitalized (An affirmative answer to any one of three questions indicated hospitalization for the inmate); 6) arrested, behavior; and 7) arrested, driving.

The percentage by Age Group columns gives the percentage of inmates within the age group (eg, 17-18, means 17 and 18 years of age, etc) that answered affirmative to the related MAST question. Note that the age groups change from two years to five years at the 25-29 age group.

The Total column gives the overall percentages for all inmates who responded affirmatively to the related MAST question regardless of age.

**Number of Inmates** — This row gives the number of inmates interviewed for each age group as well as the total number interviewed.

**Number of Alcoholics** — This row gives the number of inmates whose MAST scores were five or more.

**Number Suggestive Alcoholics** — This row gives the number of inmates whose MAST scores were exactly four.

terviewer, along with any pertinent comments made by the inmate. If an inmate maintained that he had never taken a drink, and the interviewer was convinced he was being truthful, only the personal data was taken and his MAST was scored as zero. If an inmate maintained that he had been abstinent for a period of time, MAST questions were asked in reference to the period when the inmate was drinking.


## Acknowledgements

Special thanks go to the director of the Reception Center of the Maryland Penitentiary, Mr. Gordon Kamka, for his cooperation and encouragement to conduct the study; also, to the counselors and guards at the Reception Center whose suggestions and help made this an enjoyable task and expedited its completion. Thanks also to Mr. Riley Regan, industrial program advisor, Division of Alcoholism Control, for developing and coordinating the study.



For further information or reprint requests, contact the author at 2305 N. Charles St., Baltimore, Md. 21218.



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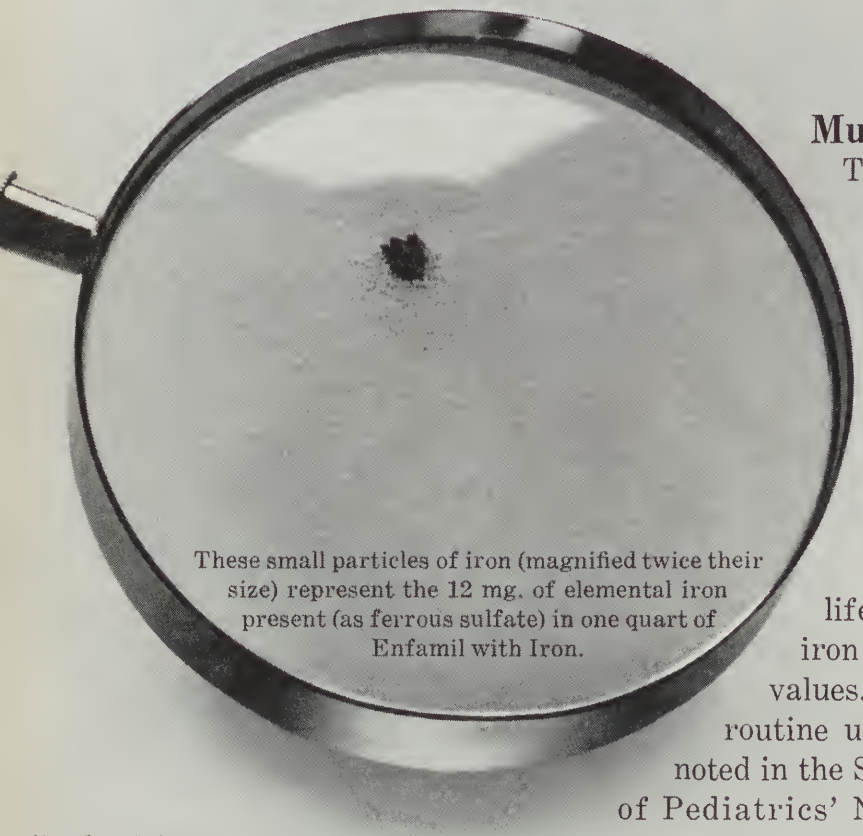
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**References:** 1. Filer, L. J.: Hospital Practice *6*:79 (June) 1971. 2. Committee on Nutrition: Iron-Fortified Formulas, American Academy of Pediatrics' Newsletter Supplement, Dec. 15, 1970. 3. Report of the Committee on Nutrition, American Academy of Pediatrics: Pediatrics *43*:134, 1969.

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*– George Sarton, from "The History of Medicine Versus the History of Art"*

# Should nongovernment scientists and physicians play a role in drug regulation?

# Opinion

**Results of a questionnaire to 7000 physicians:**

82.8%
**Physicians should play a role**

78.3%
**Independent scientists should play a role**

69.8%
**Medical academicians should play a role**

Opinion & Dialogue

# Dialog

## Should nongovernment scientists and physicians play a role in drug regulation?

## Doctor of Medicine

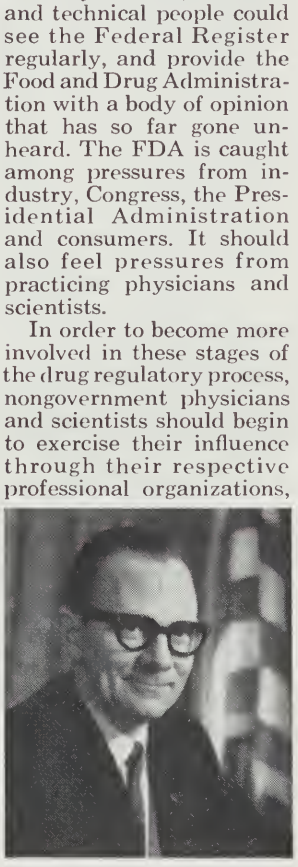
**Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant**

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized, in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications line in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn could notify the physician in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: if drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

# ue

## Maker of Medicine



**Henry W. Gadsden, Chairman & Chief Executive Officer, Merck & Co., Inc.**

In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

## Opinion & Dialogue

**What is your opinion, doctor?**
**We would welcome your comments.**

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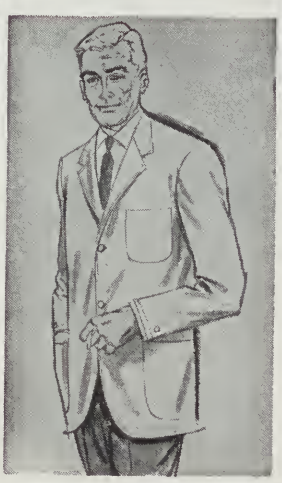
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- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin®**

brand of

**pentazocine** (as hydrochloride)

the long-range analgesic

# a new outlook in chronic pain

## of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

*Usage in Pregnancy.* Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

*Drug Dependence.* There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

*Acute CNS Manifestations.* Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

*Usage in Children.* Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Ambulatory Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

*Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

*CNS Effect.* Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

*Children Under 12 Years of Age.* Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Duration of Therapy.* Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

*Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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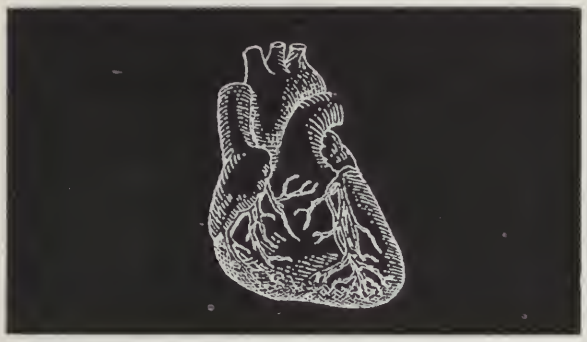
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brand of

## pentazocine (as hydrochloride)

## the long-range analgesic



MORRIS N. KOTLER, MD, EDITOR

*A Service of the Heart Association of Maryland*

**the heart page**

# CARDIAL TAMPONADE AND CONSTRICTIVE PERICARDITIS DIAGNOSIS

**RALPH SHABETAI, MD**
**University of Kentucky**
**Department of Medicine**
**Lexington, Kentucky**

*Part II of this article will appear in the May issue.*

The intrapericardial pressure in normal individuals is subatmospheric. Cardiac tamponade exists when the intrapericardial pressure is appreciably increased by fluid. Its severity depends upon the rate of accumulation and the volume of pericardial fluid. Important causes include trauma, infection, and ruptured aortic aneurysm or myocardial infarction.

Equal compression of all cardiac chambers by the fluid explains the clinical picture: elevated venous pressure, pulmonary congestion, hypotension, and a quiet heart. One or two hundred ml of fluid accumulated rapidly suffice to cause tamponade, as in trauma. In infectious and malignant effusions the onset, although less acute, may still be rapid. If an effusion collects over many days or weeks, several hundred ml may gather before tamponade ensues.

In extreme cases, clinical examination discloses impaired cerebral function, pallor, sweating, and impalpable or weak radial pulses. Cerebral symptoms are less prominent with milder tamponade but the patient may note chest discomfort and dyspnea.

Pulsus paradoxus, an abnormal inspiratory fall in arterial pressure, is almost invariable with tamponade. The pulse diminishes or entirely disappears during each inspiration. Pulsus paradoxus may be difficult to elicit under three circumstances: profound hypotension, mild tamponade, and tachypnea. When the radial pulse is impalpable, paradoxus may be elicited from the femoral pulse. To appreciate pulsus paradoxus in mild cases, it may be necessary to have the patient breathe as deeply and slowly as possible without straining at end inspiration or expiration. However, when the aim is to measure the severity rather than simply detect pulsus paradoxus, respiration should be maintained as normal as possible, because hyperventilation exaggerates pulsus paradoxus. Blood pressure is measured with a cuff, releasing the pressure as slowly and evenly as possible. Initially, systolic sounds are audible only during expiration but, as cuff pressure falls, a point is reached when the sounds are heard throughout the respiratory cycle. The pressure difference between these two points estimates pulsus paradoxus.

Elevated venous pressure is best observed with the thorax elevated, frequently to 90 degrees. Venous pulsations are visible inferior and anterior to the ear and display a single slow expansion followed by a rapid collapse synchronous with the carotid pulse. Normal inspiratory variation and fall in venous pressure is often maintained. Precordial activity is absent or diminished, but if the apex beat is palpable cardiac dullness may be percussed lateral to it. The heart sounds are usually normal, sometimes muffled. A pericardial friction rub may be heard, and DOES NOT PRECLUDE EFFUSION. The ECG may show sinus tachycardia, decreased voltage, elevated ST segments and, in severe cases, electrical alternans. The chest roentgenograph often reveals a globular increase in the cardio-pericardial silhouette with

disproportionately clear lung fields. If conditions permit fluoroscopy, it will be observed that the cardiac borders hardly pulsate while the aortic pulsations are vigorous. Hilar vessel shadows are often obliterated.

The presence of pericardial effusion can be confirmed most conveniently and safely by echocardiography. When this facility is not available, special radiological procedures such as intravenous $CO_2$ injection or angiocardiography may be employed.

### Constrictive Pericarditis

In this disorder, the heart is compressed not by fluid but by the visceral pericardium. In the majority of cases all cardiac chambers are equally involved and this explains the hemodynamic similarities to tamponade. Intrapericardial pressure cannot vary during the respiratory and cardiac cycles because the pericardial space is obliterated. This explains the differences from tamponade. The etiology is unknown in most instances, tuberculosis being much less common than formerly. Other important causes include malignancy, therapeutic radiation, collagen diseases, and infections.

Chronic constrictive pericarditis develops insidiously over many years. The pericardium often becomes heavily calcified. In recent series many cases are subacute and develop in weeks or months, a difference which reflects the changing etiology.

Patients with chronic constrictive pericarditis frequently are cachectic, pale, mildly jaundiced, and cyanosed. The venous pressure is greatly elevated and the arterial pulse pressure may be small, although pulsus paradoxus occurs in only a third of the cases. The venous pulse displays two rapidly collapsing waves, one in systole, the other in diastolic. The marked diastolic collapse may help to differentiate this condition from tamponade. The positive filling waves are much less prominent. The normal decrease in venous pressure with inspiration is absent and paradoxical expansion may be seen.

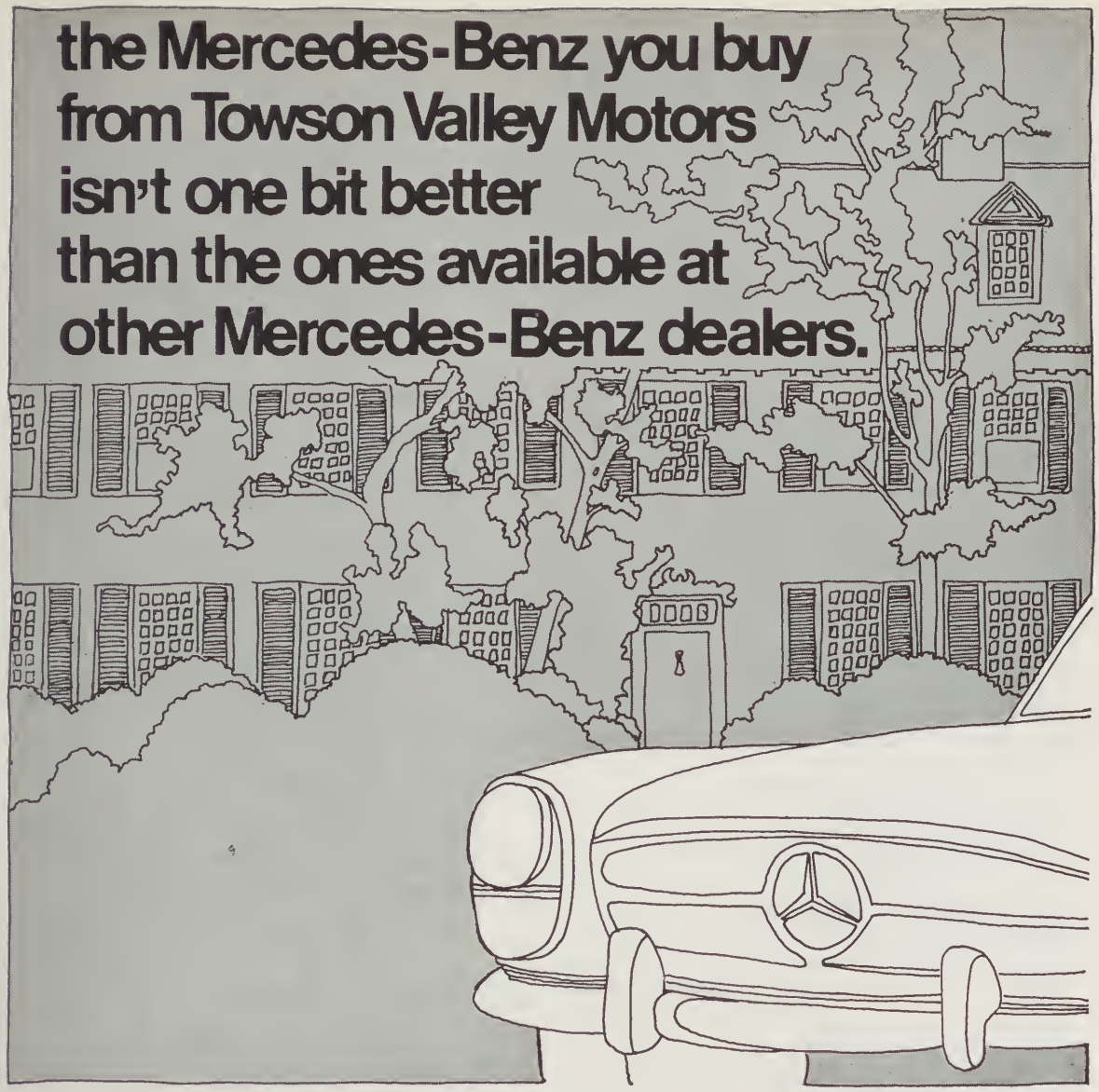
Elevated venous pressure, hepatic and renal underperfusion and congestion, and protein-losing enteropathy combine to make edema, often with disproportionate ascites, a prominent feature of the disease. The liver may be enlarged or cirrhotic and its function severely impaired.

Precordial activity is absent or decreased. Sometimes systolic retractions are found. A loud protodiastolic third heart sound is heard all over the precordium. The ECG may show wide bifid P waves until atrial fibrillation supervenes. QRS voltage is decreased and the T wave is inverted in most leads. The heart appears normal in size to moderately enlarged on chest roentgenographs. Calcification may be seen readily on plain chest films, especially in the lateral projection. Thus the radiologist may be the first to call attention to the correct diagnosis. Fluoroscopy confirms calcification and reveals decreased amplitude of motion of the heart walls.

Cachexia, anasarca, liver failure, and a high venous pressure constitute a striking clinical picture. Nevertheless the diagnosis is often missed because the patient is considered to have heart failure or primary liver disease. However the venous pressure is normal in noncardiopericardial causes of edema. If the pericardium is not calcified, final distinction from myocardial disease may require cardiac catheterization.

Subacute cases show less cachexia and liver damage. One can often obtain a history of recent acute pericarditis or chest trauma. The pericardium is not calcified and pulsus paradoxus is more common than in the chronic form. The diagnosis should be suspected in any patient with unexplained weight gain, dyspnea, edema, hepatomegaly, and raised venous pressure who does not have heart disease of easily recognized etiology.






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### April 21, 1972 12:30 PM

### PHYSIOLOGIC ASPECTS OF AGING

**Nathan Shock, PhD**
Director, Gerontology Research Center, N.I.C.H.D.
Baltimore City Hospitals

**Reubin Andres, MD**
Gerontology Research Center, N.I.C.H.D.
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| Replays: | Monday, April 24, 1972 | 12:30 PM |
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### April 28, 1972 12:30 PM

### GENETIC COUNSELING

**Peter S. Harper, MD**
Division of Medical Genetics
Johns Hopkins University School of Medicine

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### May 5, 1972 12:30 PM

### DIFFERENTIAL DIAGNOSIS OF VERTIGO

**Francis I. Catlin, MD, ScD**
Associate Professor of Laryngology and Otology
Associate Professor of Public Health Administration
Johns Hopkins University School of Medicine

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### May 19, 1972 12:30 PM

### CLINICAL ASPECTS OF AGING

**Nathan Shock, PhD**
Director, Gerontology Research Center, N.I.C.H.D.
Baltimore City Hospitals

**Reubin Andres, MD**
Assistant Chief of Clinical Physiology
Gerontology Research Center, N.I.C.H.D.
Baltimore City Hospitals

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**FUNCTIONAL UTERINE BLEEDING**

**Georgeanna Seegar Jones, MD**
Associate Professor of Obstetrics and Gynecology
Johns Hopkins University School of Medicine

**Sponsor: Frederick Memorial Hospital**

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## MAY 3, 4, 5, 1972

Baltimore Civic Center

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# WEDNESDAY, THURSDAY, FRIDAY
# MAY 3, 4, 5

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## WEDNESDAY, MAY 3

9:30 AM — Meeting of the House of Delegates

12:30 PM — *MMPAC LUNCHEON* Meeting — Baltimore Hilton Hotel

Representative **William R. Roy, MD,** U.S. Representative from Kansas, will speak on *MEDICINE AND LEGISLATIVE TRENDS AS I SEE THEM*

2:00 PM — *PEER REVIEW: PROBLEMS AND POTENTIALS.* J.M.T. Finney Fund Lecture

**Otto C. Page, MD,** President, American Society of Internal Medicine; and Associate Clinical Professor of Medicine, University of Oregon Medical School.

*A PANEL OF MEMBERS OF THE FACULTY'S PEER REVIEW COMMITTEE* will discuss actual cases that have been reviewed and will also present third party involvement.

## THURSDAY, MAY 4

### Concurrent Sessions Cosponsored By Various Specialty Societies

9:30 AM — *WHAT HAPPENS TO ABUSED CHILDREN?* — Harvey Grant Beck Memorial Lecture

**Brandt F. Steele, MD,** Professor of Psychiatry, University of Colorado School of Medicine

This lecture will be followed by a panel discussion:

Moderators: **Marvin Cornblath, MD,** Professor and Head, Department of Pediatrics, University of Maryland

**J. Alex Haller, Jr., MD,** Professor of Pediatric Surgery, The Johns Hopkins University

Participants: **Priscilla A. Gilman, MD,** Assistant Professor of Pediatrics, University of Maryland

**Diane Schulte, LLB,** Assistant State's Attorney, Baltimore City

**John P. Dorst, MD,** Professor of Radiology and Head of Pediatric Radiology, The Johns Hopkins University

9:30 AM — *PRACTICAL CONSIDERATION IN DIAGNOSIS AND TREATMENT OF HEART DISEASE* — A panel discussion

Moderator: **Donald H. Dembo, MD,** President, Heart Association of Maryland

Participants: *HYPERTENSION* — **D. Theodore Lewers, MD,** Director of Medical Education and Chairman of Department of Pathology, Maryland General Hospital, Baltimore

*HEART FAILURE* — **Kenneth B. Lewis, MD,** Cardiologist and Director of Department of Medicine, Franklin Square Hospital, Baltimore

*PERIPHERAL VASCULAR DISEASE* — **Robert J. Wilder, MD,** Cardiovascular Service, Sinai Hospital of Baltimore

*SELECTION OF PATIENTS FOR CINE-CORONARY ARTERIOGRAPHY* — **J. Richard Warbasse, MD,** Chief, Cardiovascular Service and Laboratories of the U.S. Public Health Service Hospital, Baltimore

9:30 AM *CYTOTOXIC THERAPY IN RHEUMATOID ARTHRITIS AND SYSTEMIC LUPUS ERYTHEMATOSUS* — Standish McCleary Fund Lecture

**John L. Decker, MD,** Chief of Arthritis and Rheumatism, National Institute of Arthritis and Metabolic Diseases

11:00 AM *THREE DELIVERIES THAT CHANGED THE HISTORY OF THE WORLD* — Hundley Memorial Lecture in Gynecology

**Louis M. Hellman, MD,** Deputy Assistant Secretary for Population Affairs, Department of Health, Education and Welfare

2:30 PM *CURRENT ASPECTS OF CARDIAC SURGERY* — A panel discussion

Moderator: **Joseph S. McLaughlin, MD,** Head of Division of Thoracic and Cardiovascular Surgery, University of Maryland

Participants: *VALVULAR HEART SURGERY* — **Safuh M.A. Attar, MD,** Professor of Thoracic Surgery, University of Maryland

*CONGENITAL HEART DISEASE* — **Stephen Z. Turney, MD,** Assistant professor, Division of Thoracic and Cardiovascular Surgery, University of Maryland

*THE SURGICAL TREATMENT OF MYOCARDIAL INFARCTION SHOCK* — I. Ridgeway Trimble Fund Lecture

**W. Gerald Austen, MD,** Professor of Surgery, Harvard Medical School

2:30 PM *A FUNCTIONAL RESPIRATORY CARE SERVICE* — **Martin I. Gold, MD,** Professor, Department of Anesthesiology and Head, Division of Respiratory Care, University of Maryland

2:30 PM *RAPID RECOGNITION OF SUICIDE AND MODERN MANAGEMENT METHODS* — **Joy Ruth Joffe, MD,** Phipps Clinic, The Johns Hopkins Hospital

*PRESCRIPTION DRUGS, PSYCHOPHARMACOLOGIC PATTERNS IN PRACTICE* — **Jerome Levine, MD,** National Institute of Mental Health

## FRIDAY, MAY 5

### Concurrent Sessions Cosponsored By Various Specialty Societies

9:30 AM *REHABILITATION MEDICINE* — A panel discussion moderated by **B. Stanley Cohen, MD,** President, Maryland Society of Rehabilitation Medicine

*A CURRENT APPROACH TO THE EVALUATION AND MANAGEMENT OF BELL'S PALSY* — **C. James Duke, MD,** Chief, Physical Medicine and Rehabilitation, Holy Cross Hospital, Silver Spring, Maryland

*REHABILITATION AND ACUTE MYOCARDIAL INFARCTION* — **B. Stanley Cohen, MD,** Chief, Department of Rehabilitation Medicine, Sinai Hospital of Baltimore; and Clinical Associate Professor of Rehabilitation Medicine, University of Maryland

*MANAGEMENT OF COMMON NECK PROBLEMS* — **Paul F. Richardson, MD,** Professor and Chairman, Department of Rehabilitation Medicine, University of Maryland

*ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES: PRACTICAL DIAGNOSTIC IMPLICATIONS AND LIMITATIONS* — William Royal Stokes Memorial Lecture

**Joseph Goodgold, MD,** Professor, Director, Research and Training, Department of Rehabilitation Medicine, New York University School of Medicine

9:30 AM *CLINICAL PHARMACY: A NEW PROFESSION* — A panel discussion by members of the staff of the University of Maryland School of Pharmacy

*CHANGING ROLES FOR PHARMACISTS* — **William J. Kinnard, Jr., PhD,** Dean and Professor of Pharmacology and Toxicology

*CLINICAL PHARMACISTS: PRACTICAL CONSULTANTS FOR MDs* — —**Robert A. Kerr, PharmD,** Instructor in Pharmacy

*WHAT YOU MUST KNOW ABOUT DRUG INTERACTIONS* — **David A. Blake, PhD,** Associate Professor and Chairman, Department of Pharmacology and Toxicology

*DRUG INFORMATION SERVICES, OR WHAT YOU WANT TO KNOW BUT ARE AFRAID TO ASK* — **Peter P. Lamy, PhD,** Associate Professor and Director, Institutional Pharmacy Programs; and **Winifred Sewell, BSLS,** Adjunct Assistant Professor of Pharmacy

*BIOAVAILABILITY AND DRUG PRODUCT DESIGN: IT AFFECTS YOUR PATIENT, YOUR THERAPY!* — **Ralph F. Shangraw, PhD,** Professor and Chairman, Department of Pharmacy

9:30 AM *MEDICAL LEGAL COMPLICATIONS OF INDUSTRIAL MEDICINE* — I. Ridgeway Trimble Fund Lecture

**Charles J. Frankel, MD,** Associate Professor of Surgery, University of Virginia Medical School

11:00 AM *TRANSFER FACTOR THERAPY OF IMMUNO-DEFICIENCY DISEASES* — George M. Boyer, MD, Lecture

**H. Sherwood Lawrence, MD,** Professor of Medicine, and Head of Infectious Disease and Immunology Division, New York University School of Medicine

*DISCUSSANT* — **Sheldon E. Greisman, MD,** Associate Professor of Medicine, University of Maryland

11:00 AM *CURRENT STATUS OF DIABETIC AND SICKLE CELL RETINOPATHIES*

**Arnall Patz, MD,** Director, Diabetic Retinopathy Center, The Johns Hopkins Hospital

2:00 PM *THE PROBLEMS OF MANAGEMENT OF DIABETES IN THE PRESENCE OF OTHER ENDOCRINE DISORDERS*

Harvey Grant Beck Memorial Lecture

**John J. Canary, MD,** Professor of Medicine, and Director of Division of Endocrinology and Metabolic Diseases, Georgetown University

2:00 PM *THE DOCTOR'S LEGAL DILEMMA: PRESENT AND FUTURE* — a medico-legal symposium

2:00 PM *THE TREATMENT OF TRAUMA IN THE 1970s* — A panel discussion

Moderator: **Michael E. Jabaley, MD,** Assistant Professor of Plastic Surgery, The Johns Hopkins University

Participants: *REPUBLIC VIET NAM (RVN) VASCULAR REGISTRY AS A MODEL FOR A TRAUMA REGISTRY* — J.M.T. Finney Fund Lecture

**Norman M. Rich, MD,** Chief of Vascular Surgery, Walter Reed Hospital, Washington, D.C.

*TRIAGE AND INITIAL EVALUATION* — **William P. Sadler, MD,** President, Wicomico County Medical Society, Salisbury, Maryland

*THE ROLE OF SPECIALTY UNITS IN PROBLEMS UNIQUE TO CHILDREN* — **J. Alex Haller, Jr., MD,** Professor of Pediatric Surgery, The Johns Hopkins University

*THE CONCEPT OF A BURN UNIT AND RECENT ADVANCES IN BURN MANAGEMENT* — **Gardner W. Smith, MD,** Surgeon-in-Chief, Baltimore City Hospitals

*THE SHOCK TRAUMA UNIT* — **R Adams Cowley, MD,** Chairman of the Division of Trauma and Program Director of Center for Study of Trauma, University of Maryland Hospital

*THE TREATMENT OF SHOCK* — **T. Crawford McAslan, MD,** Professor of Anesthesiology, University of Maryland

3:15 PM *SKIN MANIFESTATIONS OF INTERNAL MALIGNANT TUMORS* — William Royal Stokes Memorial Lecture

**Helen O. Curth, MD,** Assistant Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University

* * * * * * * * * * * * * *

## SCIENTIFIC AND TECHNICAL EXHIBITS

Many exhibits, both scientific and technical, will be on display at the *Baltimore Civic Center* during the Annual Meeting. **VISIT THESE EXHIBITS AND KEEP ABREAST OF SCIENTIFIC ADVANCEMENT!**

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## OTHER IMPORTANT ANNUAL MEETING ACTIVITIES

**ROUND TABLE LUNCHEON** — Holiday Inn-Downtown

There will be 16 tables at which different subjects will be discussed. All physicians will find a topic of particular interest.

**PRESIDENTIAL RECEPTION AND BANQUET** — Blue Crest North

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An opportunity for members of the Faculty and their wives to get together with their fellow members as guests of the Faculty for a fun function. A barbershop quartet will add to the enjoyment.

**ART AND HOBBY EXHIBIT** — Baltimore Civic Center

All physicians, their wives, and families are invited to complete the application which appears in the Maryland State Medical Journal, and send to the Faculty office.

**HEALTH EVALUATION TESTS** — Baltimore Civic Center

An opportunity for physicians attending the Annual Meeting to avail themselves of many screening tests. Plan to allow time to take advantage of these procedures offered by fellow physicians.

BE SURE THESE DATES ARE MARKED ON YOUR CALENDAR

**MAY 3, 4, 5, 1972**

John B. De Hoff, MD, Chairman
Committee on Program and Arrangements

# More About the Speakers at the Annual Meeting of the Medical and Chirurgical Faculty May 3, 4, 5, 1972 Baltimore Civic Center


Dr. Roy


Dr. Steele


Dr. Hellman


Dr. Rich

*See the March issue of the Maryland State Medical Journal for information about other speakers.*

### Dr. Roy

William R. Roy, MD, Congressman, lawyer, and physician will speak on *MEDICINE AND LEGISLATIVE TRENDS AS I SEE THEM,* at the Maryland Medical Political Action Committee (MMPAC) Luncheon on Wednesday, May 3, at the Baltimore Hilton Hotel. Serving his first term as United States Representative from the Second Congressional District of Kansas, Dr. Roy is one of four physicians in Congress and the only member of the 92nd Congress with both a medical and a law degree.

As a member of the Interstate and Foreign Commerce Committee and the Subcommittee on Public Health and Environment, Dr. Roy has been instrumental in drafting health legislation, including the Health Manpower Act of 1971 and the National Cancer Attack Program. In addition, Dr. Roy personally authored the Health Maintenance Organization Bill of 1971, which will be among the major health care proposals to be considered in the Second Session of the 92nd Congress.

In December 1971 the international weekly publication, *MEDICAL TRIBUNE,* commended Dr. Roy for his "Remarkable legislative contributions in the health field during 1971 which marked him as one of the most outstanding first-term members of the House of Representatives."

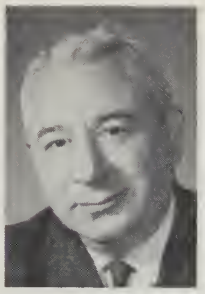
A practicing obstetrician-gynecologist in Topeka, Kansas since 1955, Dr. Roy ran for public office for the first time in 1970, winning by a large margin over the incumbent. He was a Republican until the day before he filed to run as a Democrat, and had an aggressive campaign organization that included as many Republicans and Independents as it did Democrats.

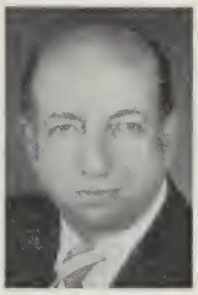
For reservations for this MMPAC Luncheon, call the office of the Medical and Chirurgical Faculty (301-539-0872).

### Dr. Steele

Brandt F. Steele, MD, will discuss *WHAT HAPPENS TO ABUSED CHILDREN?,* the Harvey Grant Beck Memorial Lecture, at the Annual Meeting of the Faculty on Thursday morning, May 4. This will be followed by a panel discussion on the medical, sociolegal, and psychiatric aspects of child abuse.

Dr. Steele is professor of psychiatry at the University of Colorado Medical Center, and also has broad training in medicine and surgery. He was graduated from the Indiana University School of Medicine. Following a research fellowship at the Thorndike Memorial Laboratory, he was an assistant resident on the surgical service and a house officer on the medical service at the Boston City Hospital. Following a residency in medicine in New York City, he was in the private practice


Dr. Frankel


Dr. Patz


Dr. Curth


Dr. Levine


Dr. Goodgold

of internal medicine in Indianapolis from 1943 to 1946. From 1947 to 1949, Dr. Steele was a resident fellow in psychiatry at the Pennsylvania Hospital, Philadelphia.

Since 1958 Dr. Steele has been chief of the Psychiatric Liaison Division, University of Colorado Medical School, where he has conducted clinical research on the battered child syndrome. He is the author of several publications on child abuse and violence.

### Dr. Hellman

On Thursday, May 4, the Hundley Memorial Lecture in Gynecology, *THREE DELIVERIES THAT CHANGED THE WORLD,* will be given by Louis M. Hellman, MD, deputy assistant secretary for Population Affairs, Department of Health, Education, and Welfare.

Dr. Hellman served as resident in obstetrics and gynecology at The Johns Hopkins Hospital, and was an associate professor in obstetrics at The Johns Hopkins University School of Medicine from 1945 to 1950. He was professor and chairman, Department of Obstetrics and Gynecology at the State University of New York, Downstate Medical Center, from 1950 to 1970.

Dr. Hellman's honorary academic positions have included visiting professor in obstetrics and gynecology at Guys Hospital Medical School in London, at the University of Florida, at the University of Newcastle upon Tyne in England, and at the University of Glasgow in Scotland. His medical degree was obtained from The Johns Hopkins University.

### Dr. Rich

*REPUBLIC OF VIET NAM (RVN) VASCULAR REGISTRY AS A MODEL FOR A TRAUMA REGISTRY* is the title of a J. M. T. Finney Fund Lecture to be presented by LCDR Norman M. Rich on Friday, May 5 at the Civic Center. Dr. Rich received his MD degree in 1960 from Stanford University Medical School, and his surgical residency training in major army hospitals.

Dr. Rich is chief of Peripheral Vascular Surgery Service at the Walter Reed General Hospital, director of the Viet Nam Vascular Registry, vascular research coordinator with Armed Forces Institute of Pathology at the Walter Reed Army Institute of Research and at the Edgewood Arsenal Research Center in Maryland, consultant to the Surgeon General in Vascular Surgery, and on the staff of the Cardiovascular Branch of the Armed Forces Institute of Pathology.

### Dr. Frankel

A second I. Ridgeway Trimble Fund Lecture will be presented by Charles James Frankel, MD, on Friday morning, May 5, during the Annual Meeting of the Faculty. The title of his discussion will be *MEDICAL LEGAL COMPLICATIONS OF INDUSTRIAL MEDICINE.*

Dr. Frankel received his BS degree at Lafayette College, and his MD degree in 1934 at Rush Medical College, University of Chicago. He has had special training in orthopedic surgery at the University of Virginia, and is board certified in this specialty. He served internships at St. Louis City Hospital and Washington University, and residencies at the University of Virginia, The Children's Hospital in Baltimore, and Shriners' Hospital in St. Louis. Dr. Frankel is associate professor of orthopedics at the University of Virginia Medical School.

In addition, Dr. Frankel received his LLB degree from the University of Virginia Law School in 1957, and has taught Legal Medicine in Medical School and Medical Law in Law School.

He is a member of the American Board of Orthopedic Surgery faculty, the American Orthopedic Association, the American Academy of Orthopedic Surgery, the International Society-

Trauma, and is vice president of the American Board of Orthopedic Surgery. He is also medical-legal editor, *Clinical Medicine,* and chief editor, *Lawyers Medical Cyclopedia.*

Dr. Frankel's publications include a monthly column on Legal Medicine in *Clinical Medicine,* as well as the revision of Volume III, *Lawyers Medical Cyclopedia.*

### Dr. Patz

Arnall Patz, MD director of the Diabetic Retinopathy Center at The Johns Hopkins Hospital, will speak on Friday, May 5, during the Annual Meeting of the Faculty on *CURRENT STATUS OF DIABETIC AND SICKLE CELL RETINOPATHIES.* Diabetic retinopathy has become the largest cause of blindness in several parts of the United States.

Dr. Patz will discuss the advantages, as well as the limitations, of treatment of diabetic retinopathy and sickle cell retinopathy with the argon laser. The use of fluorescein to document the vascular changes will be illustrated.

Dr. Patz obtained his MD degree from Emory University, served as intern and assistant physician in ophthalmology at Sinai Hospital of Baltimore, and was an ophthalmology resident at the District of Columbia Hospital.

### Dr. Curth

Helen O. Curth, MD, a diplomate of the American Board of Dermatology, will give the William Royal Stokes Memorial Lecture on *SKIN MANIFESTATIONS OF INTERNAL MALIGNANT TUMORS,* Friday afternoon, May 5, at the Baltimore Civic Center.

Dr. Curth specialized in dermatology in Germany where J. Jadassohn and A. Buschke were her teachers. She came to the United States in 1931 and became connected with the Department of Dermatology of the College of Physicians and Surgeons, Columbia University, where she is currently assistant clinical professor of dermatology.

The study of acanthosis nigricans and of other benign dermatoses has been the special interest of Dr. Curth. She has published many papers on the relationship between dermatoses and malignant internal tumors.

### Dr. Levine

*CHARACTER AND EXTENT OF PSYCHOTHERAPEUTIC DRUG USAGE IN THE UNITED STATES* is the title of the paper to be presented on Thursday afternoon, May 4, at the Baltimore Civic Center by Jerome Levine, MD. Dr. Levine is chief of Psychopharmacology Research Branch, National Institute of Mental Health; and instructor in psychiatry at The Johns Hopkins University School of Medicine. His MD degree was received from the University of Buffalo School of Medicine, and he served as psychiatric resident at the E. J. Meyer Memorial Hospital in Buffalo and St. Elizabeths Hospital in Washington, D.C.

Dr. Levine is a diplomate of the American Board of Psychiatry and Neurology. The author of over 30 publications, in 1970 he received the American Psychiatric Association Hofheimer Research Prize in Psychiatry.

### Dr. Goodgold

Joseph Goodgold, MD, professor, director, research and Training Department of Rehabilitation Medicine, New York University School of Medicine, will speak on *ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES: PRACTICAL DIAGNOSTIC IMPLICATIONS AND LIMITATIONS,* the William Royal Stokes Memorial Lecture, at the panel discussion on Rehabilitation Medicine, on Friday, May 5, at the Annual Meeting.

Dr. Goodgold is a native of New York City. He received his BA degree from Brooklyn College and his MD degree from the Middlesex University, School of Medicine, served a rotating internship and was assistant resident in Medicine at the Beth-El Hospital, New York.

He was consultant-lecturer, New York University School of Education, Postgraduate Division, director, Electrodiagnostic Service, Institute of Rehabilitation Medicine and attending physician, Department of Rehabilitation Medicine, at the University Hospital, New York University Medical Center and Bellevue Hospital. Dr. Goodgold is a Fellow of the American College of Cardiology, the American College of Physicians, and the American Academy of Compensation Medicine.



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- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

**Other Studies.** Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

**Another Point of View.** Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."




**Drug Therapy for Hypertension.** Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

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1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Kannel, William B., *et al.*: "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Consultant, Jan. 1971.

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**WARNINGS:** May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

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Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

**PRECAUTIONS:** Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided o treated by use of potassium chloride or giving food with a high potassium content. Similarly, any chlorid deficit may be corrected by use of ammonium chlorid (except in patients with hepatic disease) and largel prevented by a near normal salt intake. Hypochloremi alkalosis occurs infrequently and is rarely severe. I severely edematous patients with congestive failure o renal disease, a low salt syndrome may occur if dietar salt is unduly restricted, especially during hot weathe

Thiazides may increase responsiveness to tubocu rarine. The antihypertensive effect of the drug may b enhanced in the postsympathectomy patient. Arteri responsiveness to norepinephrine is decreased, neces sitating care in surgical patients. Discontinue drug 4 hours before elective surgery. Orthostatic hypotensio may occur and may be potentiated by alcohol, barbi urates, or narcotics.

Pathological changes in the parathyroid glands wit hypercalcemia and hypophosphatemia have been see in a few patients on prolonged thiazide therapy. Th effect of discontinuing thiazide therapy on serum ca cium and phosphorus levels may be helpful in assess ing the need for parathyroid surgery in such patient Parathyroidectomy has elicited subjective clinical im provement in most patients, but has no effect o hypertension. Thiazide therapy may be resumed afte surgery.

Use cautiously in hyperuricemic or gouty patient gout may be precipitated. May affect insulin require ments in diabetics; may induce hyperglycemia an glycosuria in latent diabetics.

**ADVERSE REACTIONS:** Rare reactions includ thrombocytopenia, leukopenia, agranulocytosis, aplas tic anemia, cholestasis, and pericholangiolitic hepatiti Nausea, vomiting, diarrhea, dizziness, vertigo, pares thesias, transient blurred vision, sialadenitis, purpur rash, urticaria, photosensitivity, or other hypersens tivity reactions may occur. Cutaneous vasculitis pr cipitated by thiazide diuretics has been reported i elderly patients on repeated and continuing exposu to several drugs. Scattered reports have linke thiazides to pancreatitis, xanthopsia, neonatal thron bocytopenia, and neonatal jaundice. When adver reactions are moderate or severe, the dosage thiazides should be reduced or therapy withdraw

*For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486*

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**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
**Contraindications:** Patients with known hypersensitivity to the drug.
**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
**Supplied:** Librium capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

# MARYLAND
## STATE MEDICAL JOURNAL

READING ROOM

MAY 1972



PRINCE GEORGE'S GENERAL HOSPITAL
CHEVERLY

# maryland state MEDICAL JOURNAL

VOLUME 21 MAY 1972 NUMBER 5


## ARTICLES:


**The Revolutionary War and its Effect on Medicine in Maryland**—Douglas Carroll, MD ..... 57

**Opthalmic Therapy — Then and Now**—Samuel L. Fox, MD ..... 64

**Ecology of Coastal Marshes**—Franklin C. Daiber ..... 70

**Anticipatory Guidance for Abortion**—Louis W. Tinnin, MD; Margaret W. Bridwell, MD ..... 73


## DEPARTMENTS:


**Your Medical Faculty at Work**—John Sargeant ..... 9

**Maryland State Department of Health and Mental Hygiene—Toxoplasmosis and Pregnancy Warning Issued** ..... 20

**Maryland Medical Political Action Committee Congressional Luncheon** ..... 27

**Woman's Auxiliary—President's Annual Report** ..... 44

**Library—Crawford Manuscript, Williams and Wilkins Claim, New Accessions** .... 46

**Action by the Commission on Medical Discipline** ..... 74

**Rehabilitation Medicine—Facial Nerve Palsy: Clinical and Electrodiagnostic Description**—Robert C. Steinman, MD ..... 84

**Heart Page—Cardial Tamponade and Constrictive Pericarditis Treatment**—Ralph Shabetai, MD ..... 92

**Occupational and Environmental Health News—Preventive Aspects of Occupational Medicine Practice**—Robert J. Barndt, MD ..... 95



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COVER—Aerial view of Prince George's General Hospital, Cheverly, Maryland.

## MISCELLANY:


Hospital Salute 5

Doctors Take Note 8

Doctors in the News 10

Director's Newsletter 13

Traffic Safety Briefs 16

Medical News Briefs 17

Component Societies 21

Book Reviews 30

Open Forum 31

Info. for Authors 41

Classified Advertising 101

Advertising Index 102



# rheumatoid arthritic blowup...

## Tandearil® Geigy

oxyphenbutazone NF

tablets of 100 mg.

*Important Note:* This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
*Indications:* Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
*Contraindications:* Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
*Warnings:* Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
*Precautions:* The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
*Adverse Reactions:* This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B) 98-146-800-E

*For complete details, including dosage, please see full prescribing information.*

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TA-8356-9



# a new outlook in chronic pain

## of moderate to severe intensity

Though Talwin® can be compared to codeine in analgesic efficacy, it is not a narcotic. So patients receiving Talwin for prolonged periods face fewer of the consequences you've come to expect with narcotic analgesics. And that, in the long run, can mean a better outlook for your chronic-pain patient.

**Talwin Tablets are:**

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe—day or night—even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin®**

brand of

**pentazocine** (as hydrochloride)

the long-range analgesic

# a new outlook in chronic pain

## of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

*Usage in Pregnancy.* Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

*Drug Dependence.* There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

*Acute CNS Manifestations.* Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

*Usage in Children.* Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Ambulatory Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

*Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

*CNS Effect.* Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

*Children Under 12 Years of Age.* Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Duration of Therapy.* Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

*Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1583)

**50 mg. Tablets**

# Talwin®

brand of

## pentazocine (as hydrochloride)

## the long-range analgesic

Med-Chi Salutes

# PRINCE GEORGE'S GENERAL HOSPITAL

A medical center complex is emerging at Prince George's General Hospital, Cheverly, Maryland, where progressive programs are providing new dimensions in patient care and new concepts of community service.

Prince George's is the largest general hospital in the Washington suburban area, and is one of the leading hospitals in number of emergency treatments in the entire metropolitan area.

It serves a geographic area of 489 square miles with a population of nearly 700,000. Hospital beds number nearly 600. A 100-bed care facility/nursing home is adjacent to the main hospital building.

As the general hospital serving Prince George's County, PGGH last year admitted 23,918 patients. Emergency Room visits jumped 12% during the past year to 66,801, nearly 10% of population.

Unlike many community hospitals that experience a low census during the summer, PGGH is occupied nearly 100% at all times, admitting only Category "A" patients—those classified as emergency admission.

A county-owned, nonprofit general hospital, now in its 28th year of service to the residents of Prince George's County, the institution is fast becoming an educational center in the training of specialized health careers.

The hospital serves as the clinical facility for the Prince George's Community College Associate Arts Degree Program in Nursing, as well as Associate Degree Programs in Radiographic Technology and Laboratory Technology. It also maintains an approved School of Practical Nursing and supports many specialized paramedical career training programs.



LIFE SAVERS—The hospital coronary care unit at Prince George's General Hospital utilizes advanced life saving equipment.

## Coronary Care Unit

A team operation, reflecting professionalism at its best, is providing intensive care for cardiac patients at Prince George's General Hospital.

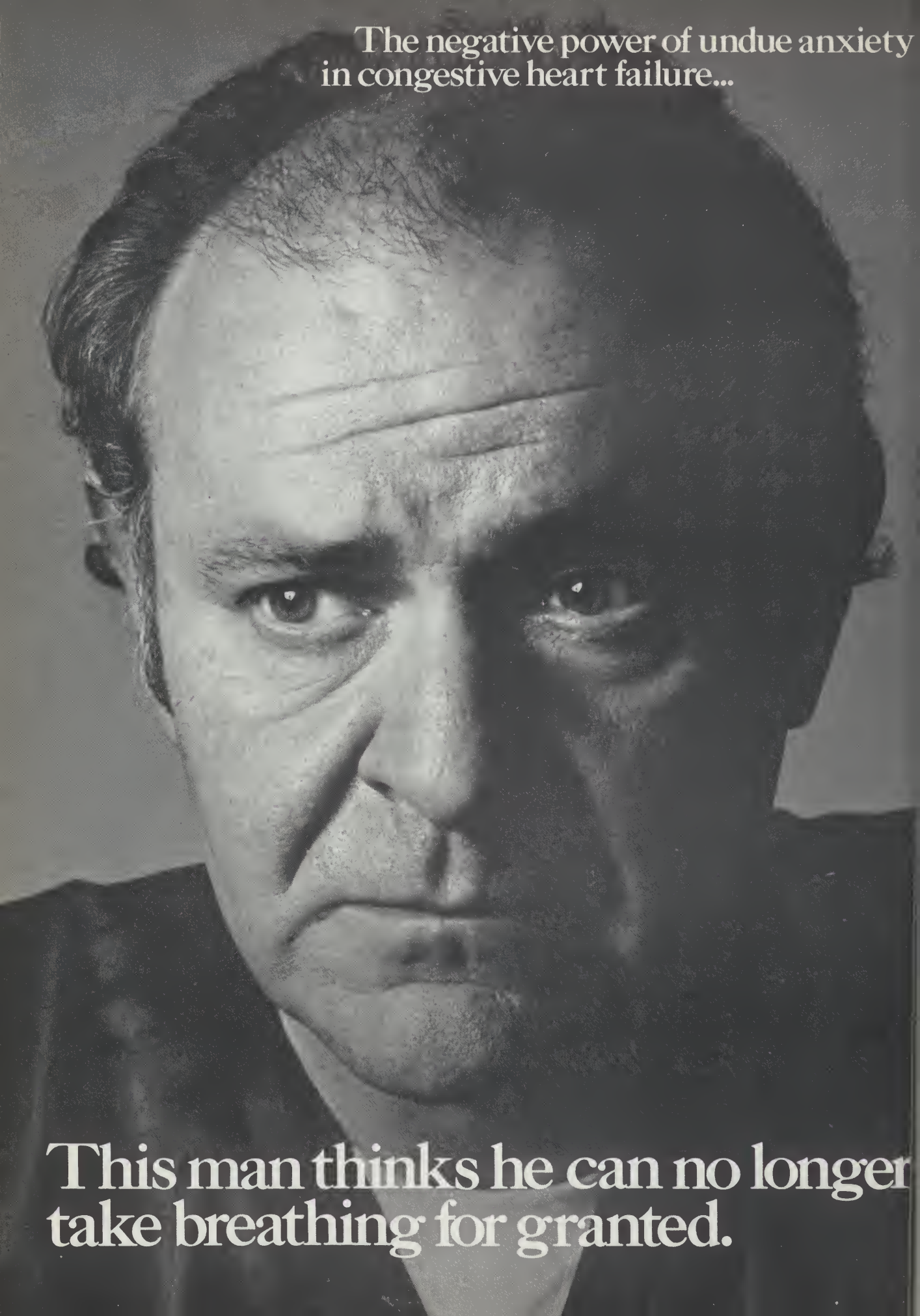
Successfully combining excellent staffing and utilization of the most advanced life saving equipment, the Coronary Care Unit at PGGH is able to monitor changes minute by minute in the cardiac patient's physical and psychological condition.

Designed to meet individual nursing and medical needs of patients having cardiac emergencies, the unit was established last year to supplement health services already provided for patients with heart disease.

National estimates show that prompt coronary care and monitoring could prevent thousands of deaths each year from heart attack complications. This unit is helping to save lives by providing constant and intensive attention for patients during the critical periods following a heart attack.

Patients are under constant surveillance. Visitors are restricted to three ten-minute visits per day by the family.

The unit is staffed with a specially trained group of medical and paramedical personnel under administrative supervision of a full-time cardiologist, Thomas Hernandez, MD, and functions under the professional direction of Bernard J. Walsh, MD, an internationally-known cardiologist.


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

**Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.**

*Aid in rehabilitation*

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

*Concomitant use with primary agents*

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

# The positive power of Libritabs®

## (chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

## t.i.d./q.i.d.

up to 100 mg daily

## for severe anxiety accompanying congestive heart failure

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

# Doctors take note...

## MARYLAND AREA MEETINGS

| | | |
|---|---|---|
| May | 17-19 | **Physical Examination of Cardiovascular System—1972.** Georgetown Univ Med Cen, Washington. Sponsors: American Heart Assoc & ACP. Contact: American Heart Assoc, 44 E 23rd St, New York, NY 10010. |
| May | 20-21 | **Assoc for Advancement of Medical Instrumentation.** AAMI/FDA Natl Conf on Med Device Stds, Washington. Contact: M J Miller, Exec Dir, AAMI, 9650 Rockville Pike, Bethesda Md 20014. |
| May | 24-26 | **Progress in Nephrology.** Georgetown Univ, Washington. Sponsor: ACP. Contact ACP, 4200 Pine St, Phila Pa 19104. |
| Jun | 12-16 | **Advanced Psychiatry for the Internist.** Sinai Hosp of Baltimore & Baltimore Dist of Columbia Inst for Psychoanalysis. Contact: ACP, 4200 Pine St, Phila Pa 19104. |

## AMERICAN COLLEGE OF PHYSICIANS

(All contacts ACP, 4200 Pine St, Phila Pa 19104.)

| | | |
|---|---|---|
| May | 22-26 | **Mgt of Common Chronic Med Diseases.** Univ of Kentucky Col of Med, Lexington Ky. 35 hrs cr. |
| Jun | 5-7 | **Progress in Internal Medicine: Emphasis on Humeral, Metabolic & Immune Mechanisms.** Univ of Iowa Sch of Med, Iowa City Iowa. |
| Jun | 8-10 | **Advances in Clinical Gastroenterology.** Yale Univ Sch of Med, New Haven Conn. |
| Jun | 12-16 | **Modern Concepts in Clinical Cardiology.** Univ of Cincinnati Col of Med, Cincinnati. |
| Jun | 26-29 | **Perspectives in Cancer Medicine.** Roswell Park Memorial Inst, Buffalo NY. |

## MISCELLANEOUS MEETINGS

| | | |
|---|---|---|
| May | 26-27 | **1st Natl Symposium on Community Emergency Med Services.** Houston. Sponsors: Harris County (Tex) Med Soc & AMA. Contact: Harris Co Med Soc, 400 Jesse H Jones Library Bldg, Houston Tex 77025. |
| May | 29-31 | **Psychopharmacology & Aging Patient.** Duke Univ Med Cen, Durham NC. Contact: Mrs Dorothy Heyman, Box 3003, Duke Univ Med Cen, Durham NC 27710. |
| May<br>Jun | 30<br>3 | **Diagnostic Roentgenology.** Univ of Cincinnati Col of Med. Refresher crs. Contact: Harold B Spitz MD, Dept of Radiology, Cincinnati Gen Hosp, Cincinnati Ohio 45229. |
| Jun | 1-3 | **7th Natl Cancer Conf.** Biltmore Hotel, New York City. Sponsors: Amer Cancer Soc & Natl Cancer Inst. No regis fee. Preregistration required. Contact: S L Arje MD, Coord on Natl Conf on Cancer Chemotherapy, c/o Amer Cancer Soc, 219 E 42nd St, New York NY 10017. |
| Jun | 8-11 | **Cardiac Arrhythmias.** Cavalier Hotel, Virginia Beach Va. Sponsors: Council on Clinical Cardiology, Amer Heart Assoc & Tidewater Heart Assoc. Contact: C L Baird Jr MD, Virginia Commonwealth Univ, Med Col of Va, Hlth Science Cen, Box 894, Richmond Va 23219. |
| Late May<br>Early Jun | | **Diagnostic Radiology.** Shriners Burn Inst, Cincinnati. 5-day crs. Contact: Harold B Spitz MD, Dept of Radiology, Cincinnati Gen Hosp, Cincinnati Ohio 45229. |
| Jun | 7-9 | **Genitourinary Radiology.** New York Med Col. Contact: Richard M Friedenberg MD, New York Med Col, 1249 5th Ave, New York NY 10029. |
| Jun | 18-22 | **AMA 121st Anl Conv.** San Francisco. 7 Postgrad crs: 1) Acute Respiratory Failure 2) Anorectal Disease 3) Antibiotics 4) Common Dermatoses 5) Experiential Learning 6) Hand Surgery 7) Liver Disease. $25 regis fee. 4-hr cr. Contact: Dept of Continuing Med Educ, AMA, 535 N Dearborn St, Chicago Ill 60610. |
| Jun | 22-24 | **Natl Conf on Human Values & Cancer.** Atlanta. Sponsor: American Cancer Society. Contact: Wm M Markel MD, Natl Conf on Human Values & Cancer, Amer Can Soc, 219 E 42nd St, New York NY 10017. No regis fee. Preregis required. |
| Jul | 22-28 | **Natl Assoc Underwater Instructors.** Honolulu. Spec crs to qualify drs in diving med. Contact: NAUI Hq, 22809 Barton Rd, Grand Terrace Calif 92324. |

# your medical faculty at work

**by John Sargeant,**
**Executive Director**

**The Council, when it met on Thursday, March 23, 1972, took the following actions:**

1. Approved recommending Emeritus Membership to the House of Delegates for various retired physicians, on the request of the Baltimore City Medical Society.
2. Adopted as Faculty policy, the following with respect to Price Controls, Phase II:

   That the Faculty is willing to accept a limitation on fee increases, only if it applies to all professional groups as well as those of physicians, dentists, and those in the health fields.
3. Reaffirmed the previous action of the Council with respect to publication of Findings of Fact by the Commission on Medical Discipline in cases that come before the Commission and action on which is final.
4. Appropriated up to $5,000 for the initial costs of formation of a Foundation for Medical Care with the understanding that additional sums, if needed, could be appropriated; and with the understanding that other interested groups would be solicited for the purpose of financial assistance in this area.
5. Adopted the following recommendation of the Peer Review Committee:

   That Council recommend to Maryland Blue Shield, Inc., that it consider a requirement that physicians performing laboratory tests on their own patients be required to participate in a Physician Evaluation Program in order to be paid for tests beyond routine urinalysis and simple bloods.
6. Referred to the Bylaws Committee a recommendation that an appeal mechanism be established in connection with Peer Review matters, so that aggrieved parties could appeal decisions rendered on a local level.
7. Approved the protocol as recommended by the Committee on Continuing Medical Education for submission to AMA. If approved by the AMA Council on Medical Education, the Faculty would then become an approved accrediting agency for Continuing Medical Education programs in the State of Maryland.
8. After hearing from Delegate Torrey C. Brown, MD, regarding the drug substitution bill before the State General Assembly, adopted a position that it would not continue to oppose this type of legislation, if the safeguards indicated are contained in the bill.
9. Adopted the report of the special panel named to deal with the problem of alleged air pollution by the Galaxy Chemical Company, in Cecil County, with the understanding that this will be forwarded to the secretary of the Department of Health and Mental Hygiene.
10. Approved continued discussions regarding a proposed conference dealing with Changing Ethics and the Quality of Life. Such a meeting would be cosponsored by the Faculty, the Department of Health and Mental Hygiene, and religious groups.
11. At the request of the Prince George's County Medical Society, approved submission of a resolution to the House of Delegates.

# Doctors in the News



Dr. Zuidema

The cover story subject of the February 21 issue of *Modern Medicine* is a Baltimore doctor, **George D. Zuidema,** MD, director of the Department of Surgery, The Johns Hopkins University School of Medicine, and surgeon-in-chief of its hospital.

Prior to coming to Hopkins in 1964, Dr. Zuidema spent four years at the University of Michigan as associate professor of surgery.

A native of Michigan, Dr. Zuidema received his MD from Johns Hopkins in 1953.

He currently serves as chairman of a study sponsored by the American Surgical Association and the American College of Surgeons on the delivery, distribution, and quality of surgical care. He also is chairman of the training grants committee of the National Institute for General Medical Sciences, and last year became a member of the Institute of Medicine.

Dr. Zuidema helped found and served as president of the Baltimore Academy of Surgery and the Association for Academic Surgery. He is a past president of The Johns Hopkins Medical Society, a consultant at five hospitals in the Baltimore-Washington area, and an editor of the *Joural of Surgical Research.*

•

**Thomas M. Wilson,** MD, Rockville, a specialist in obstetrics & gynecology, has been elected chairman of the medical staff of Suburban Hospital in Bethesda.

•

The 1972 president of the Wicomico County Medical Society is **William P. Sadler, Jr.,** MD, general and thoracic surgeon and member of the staff of Salisbury's Peninsula General Hospital. He succeeds **Talmage C. Reeves,** MD. A Princeton graduate, Dr. Sadler received his MD from Johns Hopkins.

Others named to serve this year with Dr. Sadler include **William R. Campbell,** MD, vice president; and **Aubrey Smoot,** MD, secretary-treasurer.

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**Seruch T. Kimble,** MD, Olney, has been appointed chief of staff for the Washington Sanitarium and Hospital, Takoma Park.

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South Baltimore General Hospital announces the election of **Jack Kevarian,** MD, as a vice president. **E. David Weinberg,** MD, has been re-elected to the Board of Trustees.

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Two Maryland area physicians were among a group of members of the American College of Radiology receiving certificates of Fellowship at the annual ACR meeting in Miami in April.

They are **William Robert Stecher,** Cheverly; and **Martin Allen Thomas,** Washington.

**Sherwood E. Wilson,** MD, has been named director of psychiatric education for the Maryland Department of Mental Hygiene. Dr. Wilson will be responsible for supervising psychiatric education in all of the State mental hospitals operated by the Department of Mental Hygiene.

A native of Salisbury, Dr. Wilson earned his BS at Columbia University in 1959 and his MD at the University of Maryland School of Medicine in 1964. He has been assistant clinical director at Spring Grove State Hospital since Jan 1971.

•

**Joseph D'Antonio,** MD, announces the removal of his office for the practice of internal medicine and diagnostic nuclear medicine to 7401 Osler Dr, Baltimore, Md 21204.

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**Frank J. Ayd, Jr.,** MD, Baltimore, will receive an honorary Doctor of Laws degree from St. Edwards University, Austin, Tex on May 27. This will be Dr. Ayd's fifth honorary degree. He received an honorary Doctor of Laws degree from Xavier University (Cincinnati) in 1964, an Honorary Doctor of Laws degree from Mt. St. Marys College (Emmitsburg, Md) in 1969, an honorary Doctor of Science degree from Stonehill College (North Easton, Mass) in 1970, and an honorary Doctor of Laws degree from College of Saint Elizabeth (Convent Station, NJ) in 1971.

An internationally known lecturer, writer, and psychiatrist, Dr. Ayd received his MD from the University of Maryland School of Medicine in 1945.

A group of Maryland specialists in internal medicine or related specialties who have recently become Members of the American College of Physicians includes:

**Capt. Merrill Benson,** MC USAF, Andrews;

**Bernard S. Karpers, Jr., Michael L. Levin, James J. McPhillips, Stanley R. Steinbach;** all are from Baltimore;

**LCDR N. B. Cirillo** and **LCDR Martin W. Graf,** MC USN, Bethesda;

**Thomas J. Hernandez,** Cheverly;

**Colen C. Heinritz,** Fallston;

**John G. Green,** Havre de Grace;

**Robert D. Deitz,** Hyattsville;

**Paul G. Ventry,** Potomac;

**Joel A. Reiskin** and **John S. Saia,** Rockville;

**Jacob D. Nagel,** Towson; and

**Raymond T. Benack,** Wheaton.

These new Members are doctors who graduated from medical school at least five years ago and who have limited their practice to internal medicine or a related specialty and have submitted evidence of their eligibility to take their specialty board exams.

The College also has a higher membership category, called Fellows, to which Members proceed as they gain experience.

•

**Louis O. Olsen,** MD, Baltimore, was elected to active membership in the American Academy of Family Physicians, formerly known as the American Academy of General Practice.



**Dr. Pepper**

The post of commissioner of mental hygiene will be assumed on July 15 by **Bertram W. Pepper,** MD, according to announcement by Neil Solomon, MD, Maryland's secretary of health and mental hygiene.

A native of New York, Dr. Pepper is presently associate commissioner of the New York State Department of Mental Hygiene and director of the Bureau of Children's Services in that state.

**Irene Hitchman,** MD, will continue to serve as acting commissioner until Dr. Pepper takes over his post.

Dr. Pepper received his BS from City College of New York in 1953, his MD from New York University College of Medicine in 1957, and a Master of Science degree in Community Psychiatry from Columbia University School of Public Health and Administrative Medicine in 1964. He is certified in Psychiatry by the American Board of Psychiatry and Neurology.

"The new commissioner has great interest in community health facilities but this interest is balanced by his knowledge of the operation of mental hospitals," Dr. Solomon said. "We in Maryland have been making steady progress in the field of community mental health services since the Maryland General Assembly in 1966 passed the Community Mental Health Services Act, and I am sure that Dr. Pepper will implement policies that will help us progress toward the goal of that Act."

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**Victor A. McKusick,** MD, Baltimore, professor of medicine and chief of the Division of Medical Genetics at The Johns Hopkins University School of Medicine, was among a group of six prominent physicians receiving the John Phillips Memorial Award for distinguished contributions in internal medicine. The award was made by the American College of Physicians at the opening meeting of the College's 53rd Annual Session in Atlantic City on April 17.

Dr. McKusick is one of the nation's leading authorities on the application of genetics to medical practice.

Other awards included the Alfred Stengel Memorial Award, presented to an individual or institution for major contributions to community service and the improvement of health, to the National Institutes of Health. **Robert Q. Marston,** MD, Bethesda, director of the Institutes, received the award.

•

**John J. Curry,** MD, Silver Spring, was elected assistant treasurer of the American College of Cardiology at the annual business meeting in Chicago on March 4. The College's 5,000 members comprise most of the heart disease specialists and cardiovascular research scientists in the country.

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# executive director's newsletter

May 1972

**HOME CALL SERVICES**

Those physicians who are participating in arrangements with organized services to provide house calls on their behalf should be aware of a ruling of the Faculty's legal counsel. This reads, in part, as follows:

"...the subscribing physician should be wary of the charge that he has abandoned his patient if the qualifications of the servicing physician are inadequate for the required treatment."

**PRECEPTORSHIP WANTED**

Graduates of a qualified Physician Assistant course are seeking preceptorships throughout the country. One student has expressed a preference to serve such a preceptorship in Maryland.

Interested physicians may contact Suzanne B. Greenberg, associate professor and program director, Northeastern University, Boston, Mass 02115.

**KIDNEY FUNDS**

A group calling itself The American Kidney Fund has been soliciting funds by direct mail. This group is in no way associated with the Kidney Foundation of Maryland, an affiliate of the National Kidney Foundation.

This information is brought to the attention of Faculty members, so any confusion that may exist may be clarified.

**CORRECTION**

In the January report of Your Medical Faculty at Work, reference was made to a change in policy for xerox copies of library material. This should have read 50 single pages will be provided all active members at no charge. Pages beyond this number will be billed to the member requesting them.

**NEW BNDD REQUIREMENTS**

Effective May 1, 1972, new BNDD official order forms are the only ones with which physicians may requisition Schedule I and II controlled drugs. After April 30, old forms will not be honored by BNDD.

NEW BNDD REQUIREMENTS (cont'd)

A requisition for these new order forms should request BND 222D from the local BNDD office. These are requisition forms for obtaining a supply of the new order forms.

USE OF TERM "MD"

The Faculty office has had several inquiries recently regarding the use of the term MD for those physicians who hold a Maryland license and who have graduated with degrees such as ChB, and similar degrees equivalent to the MD degree in the USA.

The Attorney General has ruled that

> "...One who is a qualified physician may use the designation (MD) regardless of the type of degree previously awarded him by an educational institution. 'MD' indicates professional licensing status, not degree status."

BLUE SHIELD FIGURES

Blue Shield, in its quarterly report ending December 31, 1971, indicated that Plan A Membership accounted for only 3.35% of the total enrollment, reduced from 6.6% a year previous. In numbers of persons involved the totals are 42,839 this year compared to 80,062 a year ago.

Other data provided in the report shows that the rate of utilization increased noticeably in most categories during 1971. Just about all services were included in the increase, except for obstetrical services. The biggest spurts were for services rendered in physicians' offices (up 17.9%); hospital outpatient departments -- minor surgical procedures, laboratory tests and radiological examinations -- (up 17.9%, 26.0%, and 38.5% respectively).

GENERAL ASSEMBLY ACTIVITY

Be on the lookout for the final issue of The Assemblyman for 1972. This covers final actions on all bills introduced, considered, rejected, amended, killed, adopted or enacted.

For specific questions on various bills, contact the Faculty office.

John Sargent
Executive Director

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# Traffic Safety Briefs

At the 15th Annual Meeting of the American Association for Automotive Medicine, A. J. McLean (Harvard School of Public Health) described a study of 29,000 pedestrians who were killed or injured in New York State in 1970. Pedestrians are injured less frequently than occupants of motor vehicles, but the ratio of deaths to injuries is four times as high for pedestrians as for occupants. Pedestrians comprise one third of all motor vehicle deaths in New York State, a fact that underscores the need to direct a greater proportion of the total injury-reduction effort toward pedestrians.

One tenth of all fatalities were hit-and-run incidents. The most severe pedestrian injuries occurred during the middle of the night when emergency rooms may be poorly staffed.

It is estimated that one out of eight New York City taxicabs injures a pedestrian during a "working life" of two years. Statewide, at least one passenger car in 50 will hit a pedestrian during a six-year life span. These figures point to the need to design vehicles in such a way as to minimize pedestrian injuries.

●

Ronald L. Krome (Wayne State University School of Medicine) and his associates reported on a survey of the 35 emergency care facilities in the Detroit metropolitan area. They found that five lacked 24-hour medical coverage. Six emergency departments had no defibrillator, eight had no electrocardiogram, and two had no endotracheal tubes available. The majority did not have operating teams or anaesthesia available 24 hours a day. Half of the emergency departments could handle no more than two critical patients at any one time.

Review of admitting policies indicated that financial status was more likely to influence admission policy in the case of psychiatric emergencies (narcotic addicts, violent patients, etc) than in the case of other types of emergencies.

The evaluating team concluded that 15 (44%) of these emergency departments should handle neither major surgery nor trauma. When more stringent criteria were applied, they felt that 86% of the hospitals should not handle major trauma.

●

Pre-arrest screening for alcohol in drivers is uncommon in the United States. Such tests, if sufficiently accurate, could help police officers to determine whether a driver should be charged with driving while intoxicated and taken to the police station for a more accurate quantitative test. Brian O'Neill (Insurance Institute for Highway Safety) and Richard Prouty (North Dakota State University) evaluated the accuracy of disposable screening devices that have been offered for use by law enforcement agencies.

Tests with most of the devices resulted in a large proportion of false positive or false negative readings. The former may lead to the arrest of drivers who will then "pass" a quantitative test; the latter may lead to release of drivers whose blood alcohol concentration exceeds the legal limit.

The authors recognize the need for development of accurate breath screening devices. They caution that the use of devices producing excessive errors will hamper progress toward effective countermeasures against alcohol abuse.

●

The American Association for Automotive Medicine encourages research and programs relating to reduction of automotive deaths and injuries, and promotes the growth and dissemination of knowledge in the field of highway and vehicular safety. Inquiries regarding membership or proceedings of the annual meetings may be addressed to 801 Green Bay Road, Lake Bluff, Illinois 60044.

SUSAN P. BAKER, MPH, Editor
Assistant Professor
Johns Hopkins School of
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# MEDICAL NEWS BRIEFS



CEREMONIAL—Astronaut Robert F. Overmyer (Maj, USMC), assisted by Congressman Paul S. Sarbanes of Maryland's 4th District, cut the EKG ribbon that officially opened Phase III of St. Agnes Hospital's coronary care program. From the left, participants were Raymond D. Bahr, MD, director of the Coronary Care Unit; Sister Alberta, Daughters of Charity, administrator; Sister Teresa (partially hidden), assistant administrator; astronaut Overmyer; Mark A. Krohn, associate administrator; and Congressman Sarbanes.

## Astronaut Officiates At Hospital Ceremony

Astronaut Robert F. Overmyer (Maj, USMC), cut the ceremonial ribbon that officially opened Phase III of St. Agnes Hospital's (Baltimore) coronary care program on March 17.

According to Raymond D. Bahr, MD, director of the hospital's Coronary Care Unit, Phase III incorporates use of a new telemetry system known as Space Labs Apollo/70, installed by Skill Surgical of Baltimore.

St. Agnes has become the first hospital in Maryland to introduce such a comprehensive and progressive coronary care system for the rehabilitation of heart attack patients, Dr. Bahr reports.

The system is similar to the one that monitored the heartbeats, temperatures, and respiration rates of astronauts on the moon.

It provides a signal by wave transmission from a pocket-size transmitter on the patient to a monitor at the nurses' station.

It is wireless, allowing the patient complete freedom of movement in and out of bed.

It uses computer technology to provide an entirely new EKG monitoring display.

Its superbright memory traces show a full eight seconds of data moving steadily across the screen like an illuminated strip chart record. It can be stopped and held indefinitely for detailed view.

The hospital uses the system to keep watch on the heartbeat patterns of coronary patients. Doctor Bahr reported:

"Wires from two sensors are taped to a patient's chest and lead to a small transmitter about the size of a paperback book. The sensors pick up and beam electrical impulses generated from the tissues of the heart through the portable transmitter to a monitor at the nurses' station. There doctors and nurses can watch a monitoring of heartbeat patterns for dangerous irregularities that could result in circulatory arrest.

"Without going into all the technical details, the many advantages of the new system are obvious," Dr. Bahr stated.

A cardiotachometer or heart rate meter on the monitor can be set so that when a patient's heartbeat rises above or drops below a certain rate, a red warning light goes on and an alarm sounds to alert physicians and nurses on duty.

At the same time, automatic monitoring equipment begins to record the disruptive patterns on a permanent record.

A doctor called during an emergency can detach the recording of the patient's heartbeat to see exactly what has happened before he starts treatment.

St. Agnes Hospital has two Apollo/70 units with the capability of monitoring a total of eight patients.

## BLINDNESS PREVENTION RESEARCH GRANTS

The National Society for the Prevention of Blindness reports that it will allocate a substantial portion of its research funds to provide prompt support to promising investigators who have not received extensive financial support for research in the past for conducting pilot projects with annual allocations no greater than $5,000 and not currently financed by other sources.

Acceptable projects are those which may contribute to basic understanding of eye function and disease, improve diagnosis and treatment, or directed toward the prevention of an eye disease.

Grants are made for a one-year period with a two-year maximum. Applications are accepted any time during the year; awards are made quarterly.

Application forms and further information may be obtained by writing to the Committee on Basic and Clinical Research, National Society for the Prevention of Blindness, Inc., 79 Madison Ave., New York, N. Y. 10016.

## MEDICAL FILMS

The American College of Radiology has issued a new brochure on medical films made available through their support. These films have been made under supervision of physicians and are excellent for continuing education, seminars, postgraduate courses, etc.

A brochure may be secured by writing the ACR at 20 North Wacker Drive, Chicago, Ill. 60606. Prints may be purchased from ACR or borrowed from these motion picture libraries:

American Medical Association
Motion Picture Library
535 North Dearborn
Chicago, Ill. 60610

National Medical Audio-visual Center
Station K
Atlanta, Ga. 30324

## LIBRARY RELOCATED

The Medical Motion Picture Library of the American College of Surgeons has been relocated from Chicago to Danbury, Conn., and will be housed with the Davis & Geck Surgical Film Library.

The action was approved recently by the ACS Board of Regents and is designed to increase efficiency of distribution. Contact ACS if a new film catalog is desired.

## INSTRUCTORS APPOINTED

The appointment of 46 Maryland emergency medical technicians-ambulance instructors has been announced by Neil Solomon, MD, Maryland's Health and Mental Hygiene secretary.

All 46 are qualified to teach emergency medical and rescue techniques to fire, ambulance, and rescue personnel within their communities, according to Dr. Solomon. While there have been trained emergency personnel operating in Maryland for many years, these appointments should further upgrade the level of training for all emergency personnel.

Each new instructor completed at least 40 hours of emergency medical training at either the University of Maryland or at the Delaware State Fire School.

## Gastroenterology Awards

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc, of Fort Washington, Pa, announces the 1972 Rorer Awards Contest for the best papers in gastroenterology.

A first prize of $500 will be granted for the best unpublished paper in gastroenterology or an allied subject. Second prize is $300; third prize is $200.

Similar awards will be made for the best papers published in their official publication, *The American Journal of Gastroenterology,* for the one-year period ending June 30, 1972.

All entries must be received by June 15 and should be addressed to the Research and Education Committee, ACG, 299 Broadway, New York, NY 10007.

## NO SMOKING

The availability of NO SMOKING signs has been called to our attention by the State Journal Group.

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## FDA to Evaluate O-T-C Drugs

The Food and Drug Administration has embarked upon a major scientific and regulatory program designed to assure that all over-the-counter drugs are safe, effective, and accurately labeled for the relief of minor illnesses and discomfort.

Responsibility for evaluating the over-the-counter drug products on a class-by-class basis will rest with expert panels, to be appointed by FDA. Each panel will consist of physicians with extensive knowledge of the drugs involved. A National Drug Advisory Board, chaired by Food and Drug Commissioner Charles C. Edwards, MD, will supervise the evaluation.

The basic scientific undertaking will take two to three years to complete. Meanwhile, FDA is continuing implementation of the National Academy of Sciences review of efficacy of prescription drugs. The aim of both programs is to assure physicians and the public of the safety, efficacy, and accurate labeling of all marketed drugs.

## Homocystinuria Study

The cooperation of physicians is requested in the referral of patients with homocystinuria for a study being conducted by the National Institute of Arthritis and Metabolic Diseases' Digestive and Hereditary Diseases Branch at the Clinical Center, National Institutes of Health, Bethesda, Md.

Currently under investigation are various metabolic and therapeutic aspects of this disease with particular interest in evaluating patients with documented homocystinuria, whether known to respond to vitamin $B_6$ or not.

Physicians interested in having their patients considered for admission to this study may write or phone Jeffery R. Poole, MD, or Jerry D. Gardner, MD, Clinical Center, Room 9-D-15, NIH, Bethesda, Md 20014, (301) 496-4201.

## Hospital Expansion

The first in what is described as "a series of planned expansion moves" has been announced by the South Baltimore General Hospital. Contracts for $195,000 have been let for a new 42-bed unit. Utilization of the new unit (medical or surgical) will depend on patient traffic flow between now and August.

Now licensed for 366 beds, the hospital will have 408 bed units when completed in September.

According to Carl Behm, hospital director, the cost will come to less than $5,000 a bed; many hospitals run as high as $50,000 per bed.

Mr. Behm further stated that the expansion was made necessary by the constantly increasing demand for health services. "Patient population increased 8% in 1971, and in 1970 we had an increase of 25% over the preceding year!"

## New Program

The American Medical Association has officially accredited a four-year Residency Training Program in Anatomic and Clinical Pathology at South Baltimore General Hospital.

Inquiries should be directed to Watson Kime, MD, director of the Clinical and Pathological Laboratory at the 3001 South Hanover St, Baltimore health facility.

## Public Health Courses

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces postgraduate courses of instruction for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of Public Health. Tax-exempt Fellowships are available, consisting of support for the trainee and his dependents, tuition, and fees.

Program areas at the present time include nine-month programs in Maternal and Child Health, Health of School-Age Children and Youth, and Family Planning. Twenty-one-month programs in Care of Handicapped Children, Comprehensive Health Care, and Perinatology are also available.

Applications are now being accepted for the group entering September *1973*. For information, write to Helen M. Wallace, MD, School of Public Health, University of California, Berkeley, Calif 94720.

## Ground Breaking

Ground was broken on March 4 at Salisbury for the Eastern Shore Regional Mental Retardation Center, the State's second regional facility of this nature.

The new unit will cost about $5 million and is scheduled for completion in the summer of 1974. Approximately 300 people will staff the Center.

Located on Route 12 (Snow Hill Road) at East College Ave south of the city, on 75 acres of land given by Wicomico County, the Center will house 225 full-time residents and will serve the nine counties on Maryland's Eastern Shore.

NEIL SOLOMON, MD, PhD, SECRETARY

Maryland State department of health and mental hygiene

# TOXOPLASMOSIS AND PREGNANCY WARNING ISSUED

The Preventive Medicine Administration of the Maryland Department of Health and Mental Hygiene, through its chief, Benjamin D. White, MD, has issued a statement concerning Toxoplasmosis infections and pregnant women.

According to Dr. White, Toxoplasmosis is a common disease occurring in man and animals throughout the world. It is generally transmitted to humans through eating raw or undercooked meat and through contact with cat feces.

The disease generally runs a mild course in children and adults and rarely results in significant complications. In adults there are generally no noticeable symptoms, although some individuals may become sick with symptoms resembling infectious mononucleosis or the common cold. It is believed that all individuals are susceptible to initial infection with Toxoplasma, and studies reveal that an estimated one fourth of the adult population in the United States have antibodies indicating infection at some time in their life. Such persons are presumed immune to further infection.

As with Rubella (German Measles), Dr. White said, a serious effect of Toxoplasmosis is its ability to cause birth defects if caught during pregnancy. Some studies, he reported, show that approximately one out of every 1,000 newborns has a positive serologic test for the disease, and one out of five newborns with the positive reactions indicate the child has defects.

Because of the possibility of infection of pregnant women with Toxoplasmosis, a memo has been issued to all local health officers and includes these recommendations:

1) Pregnant women should be advised to avoid eating raw meat or associating closely with cats. If there are cats in the home, someone other than the expectant mother should be assigned the task of emptying the litter box.

2) Pregnant women with cats in the household, or who eat raw meat, should have a serologic test for Toxoplasmosis. The test is available by submitting 10 cc of clotted blood to the Maryland Public Health Laboratory, 16 East 23rd Street, Baltimore, Md. 21218, through the family physician.

3) Introducing of newly acquired cats to households where there is a pregnant woman should be avoided, because its prior diet and life history are generally unknown.

4) Cats should not be fed raw meat or allowed to hunt if there is a pregnant woman in the house or small children who have not had adequate hand-washing training. Prepared cat foods are recommended over raw meats because they contain all necessary food values and are free from possible bacterial infection.

5) A twice-yearly fecal examination of cats by licensed veterinarians is essential, in order to insure their good health and to protect humans from infection.

6) Pregnant women living in households where there are pet cats should make their physicians aware of this fact.

## HELP WANTED

The need is still great for trained medical personnel to help care for this nation's growing number of sick and injured persons, reports the Health Insurance Institute.

The United States now needs 48,000 more doctors, 157,000 more nurses and 264,000 other professional and technical medical personnel, according to the National Institutes of Health Statistics.

# FREDERICK COUNTY MEDICAL SOCIETY

"Two of the American presidents assassinated could probably have survived the assassins' bullets, but the other two presidents were too mortally wounded to recover." This was the personal opinion expressed by the guest speaker, Robert Burnett, MD, to the members of the Frederick County Medical Society at their March meeting.

Dr. Barnett, a practicing surgeon in Montgomery County, demonstrated a profound knowledge of his subject as he recounted the historical events surrounding the assassinations of presidents Lincoln, Garfield, McKinley, and Kennedy. With the aid of slides he demonstrated the type wounds inflicted in each case, the care and treatment rendered to each victim, and the findings discovered on autopsy.

In the cases of Lincoln and Kennedy there was so much brain damage from the bullets that survival was virtually impossible. However the bullet fired from the revolver held by Charles J. Guiteau into the lower back of President Garfield did not immediately cause his death; in fact it was not until two months and 17 days following the shooting that he died. During this time many efforts were made to locate the bullet. The wound was probed with the bare finger by several different physicians, and even Alexander Graham Bell was called in with his new machine, an electro-magnetic device, to try to locate the site of the bullet. His efforts were unsuccessful. Dr. Barnett outlined the many complications that occurred during Garfield's care until suddenly he developed severe chest pain and expired. The autopsy revealed a rupture of the splenic artery from an aneurysm which had developed from the original wound.

President McKinley was shot by anarchist Leon Czolgosz, the bullet penetrating the abdomen. One hour and 15 minutes, which Dr. Barnett stated, "certainly was in record time," McKinley was undergoing surgery under ether anesthesia. The stomach was found to be perforated through both walls. These were closed, but the bullet was not located. McKinley developed fever and abdominal pain the day following surgery, but seemed much better two days post-op. This time Thomas Alvah Edison was called in to try a new machine he had invented to locate the bullet. His attempts were unsuccessful. When severe abdominal pains developed a few days later, McKinley was given a dose of castor oil. He promptly became worse and expired two days later. The autopsy findings revealed necrosis of the pancreas.

The many other detailed accounts of the assassinations, methods of treatment, and the descriptions of the assassins as related by Dr. Barnett were most informative and thoroughly enjoyed by the members of the Society.

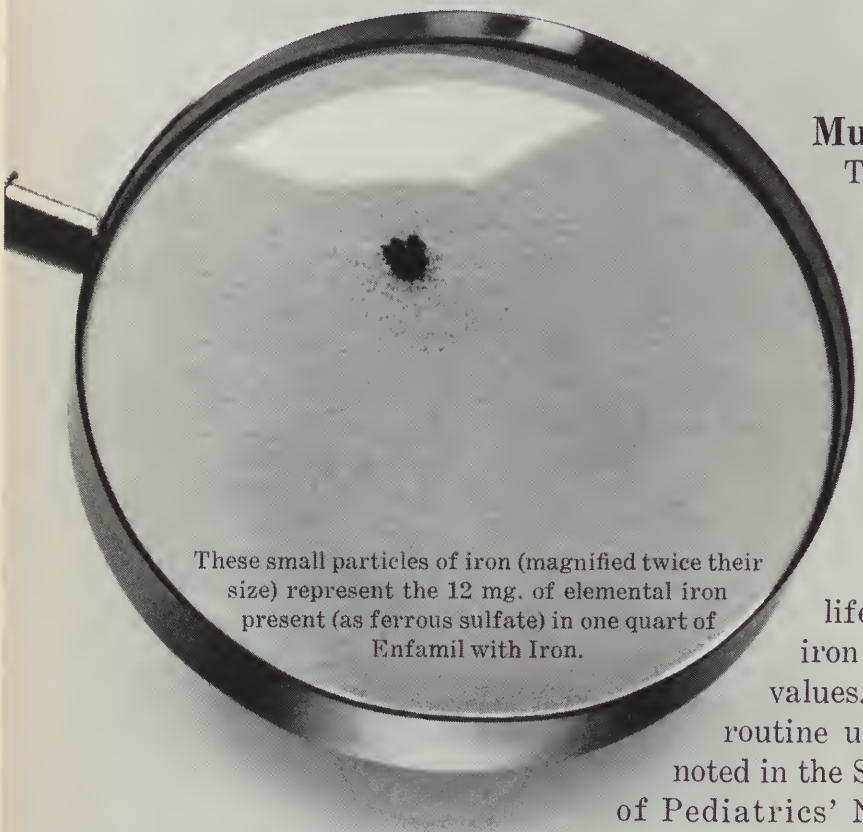
In the business session of the meeting, Frank Damazo, MD, reported on the status of local nursing homes and requested physicians to conform to the requirements of keeping charts up to date in order to remain accredited. The members were pleased to hear that in patient care, nursing care, facilities, and all aspects of good medical attention, the nursing homes excelled. It was only in the paper work required of the attending physicians that a problem existed. Having been made aware of these circumstances, the members indicated a willingness to correct this situation immediately.

A discussion was held regarding the bill before the state legislature which would require every hospital in the state to grant privileges to any licensed physician. It was pointed out that in the case of the local hospital which does not have a resident staff, if such a requirement were imposed, physicians from distant areas could admit patients, perform surgery, but not be immediately available for follow-up care or to care for any post-operative complication that might arise. It was therefore felt that such a bill would not be in the patients' best interest. The members voted to go on record in opposition to the proposed bill. An incidental fact brought out in the discussion was that the local hospital has never refused privileges to any qualified physician living within a reasonable distance of the hospital.

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# Preventing iron deficiency in infancy is tragically simple.



These small particles of iron (magnified twice their size) represent the 12 mg. of elemental iron present (as ferrous sulfate) in one quart of Enfamil with Iron.

## Multiply this small dot 365 times.

That's the amount of iron provided du ing one year by daily 32-fluid ounc feedings of Enfamil with Iron...a amount which can help prevent nutr tional iron deficiency in infancy.

This, the most prevalent nutr tional deficiency in the United State has been shown to occur in from 25 t 75 per cent of one-year-olds in impov erished areas.[1]

Especially during the first year o life, the infant requires a predictable dail iron intake to maintain normal hemoglobi values. This requirement can be met by th routine use of iron-fortified milk formula, a noted in the Supplement to the American Academ of Pediatrics' Newsletter of December 15, 1970 "...health professionals should engage in a program of public education to convince America mothers to provide their infants with a source of dietary iron. This can be achieved by continu ing an iron-fortified formula as long as the infant is bottle fed, and then using the same iron fortified formula as beverage milk along with the usual solid foods until the infant is at least 1 months of age."[2]

Enfamil with Iron contains 12 mg. of elemental iron per quart, normal dilution. This iron level, along with the iron contained in the solid foods in an infant's diet, is consistent with the American Academy of Pediatrics' recommendation on daily iron intake.[3]

Enfamil with Iron is available in a wide variety of forms, convenient for both bottle and cup feeding. It supplies the iron intake infants must have...at a cost comparable to whole milk.

References: 1. Filer, L. J.: Hospital Practice *6*:79 (June) 1971. 2. Committee on Nutrition: Iron-Fortified Formulas, American Academy of Pediatrics' Newsletter Supplement, Dec. 15, 1970. 3. Report of the Committee on Nutrition, American Academy of Pediatrics: Pediatrics *43*:134, 1969.

ENFAMIL with Iron is available as: Concentrated Liquid in 13-fl. oz. cans, Ready-To-Use in 8- and 32-fl. oz. cans, Powder in 16-oz. (1-lb.) cans, and as ENFAMIL NURSETTE® in 6-fl. oz. bottles.

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Infant Formula provides 12 mg. ferrous iron per quart—at no extra cost

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# A gratifying announcement about Empirin® Compound with Codeine




**You may now specify up to five refills within six months when you prescribe Empirin Compound with Codeine (unless restricted by state law).**

**It is significant in this era of increased regulation, that Empirin Compound with Codeine has been placed in a less restrictive category. You may now wish to consider Empirin with Codeine even more frequently for its predictable analgesia in acute or protracted pain of moderate to severe intensity.**

**Empirin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.**



# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

fections caused by susceptible strains
pneumococci, streptococci, and
aphylococci, including penicillin-
sistant strains. Staphylococcal strains
sistant to Lincocin (lincomycin
ydrochloride, Upjohn) have been
covered. Before initiating therapy,
lture and susceptibility studies should
performed. Lincocin has proved
luable in treating patients hyper-
nsitive to penicillin or cephalosporins,
nce Lincocin does not share
tigenicity with these compounds.
owever, hypersensitivity reactions
ve been reported, some of these in
tients known to be sensitive to
nicillin.

**ell tolerated at infusion site:** Lincocin
travenous infusions have not
oduced local irritation or phlebitis,
nen given as recommended. Lincocin
usually well tolerated in patients who
e hypersensitive to other drugs.
evertheless, Lincocin should be used
utiously in patients with asthma or
nificant allergies.

patients with impaired renal function,
e recommended dose of Lincocin
ould be reduced to 25—30% of
e dose for patients with normal
dney function. Its safety in
egnant patients and in infants
s than one month of age has
t been established.

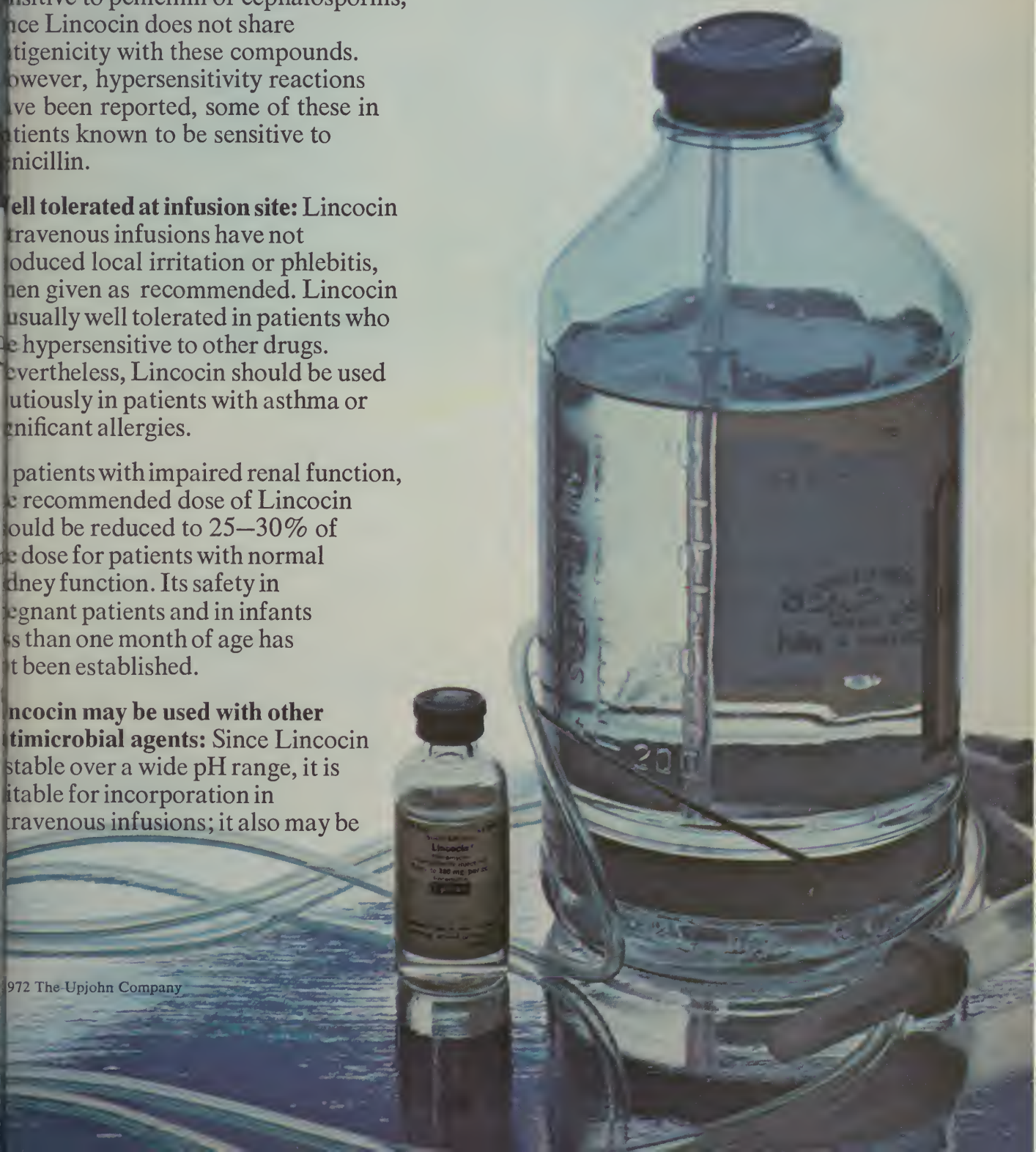
**ncocin may be used with other
timicrobial agents:** Since Lincocin
stable over a wide pH range, it is
itable for incorporation in
travenous infusions; it also may be
administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

# Lincocin®

## (lincomycin hydrochloride, Upjohn)

**Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.**

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatm
*Skin and mucous membranes*—Skin ras
urticaria, vaginitis, and rare instances of
foliative and vesiculobullous dermatitis h
been reported. *Liver*—Although no direct
lationship to liver dysfunction is establish
jaundice and abnormal liver function t
(particularly serum transaminase) have b
observed in a few instances. *Cardiovasc*
—Instances of hypotension following pa
teral administration have been report
particularly after too rapid IV adminis
tion. Rare instances of cardiopulmonary
rest have been reported after too rapid
administration. If 4.0 grams or more adn
istered IV, dilute in 500 ml of fluid
administer no faster than 100 ml per h
*Special senses*—Tinnitus and vertigo h
been reported occasionally. *Local reacti*
—Excellent local tolerance demonstrate
intramuscularly administered Linco
(lincomycin hydrochloride). Reports of p
following injection have been infrequ
Intravenous administration of Lincocin
250 to 500 ml of 5% glucose in disti
water or normal saline has produced
local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500*
Capsules—bottles of 24 and 100. *Ste*
*Solution, 300 mg per ml*—2 and 10 ml v
and 2 ml syringe. *Syrup, 250 mg per 5*
—60 ml and pint bottles.

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DeWITT E. DeLAWTER, MD, Chairman
MRS. FRANCIS C. MAYLE, Editor

# Maryland Congressional Delegation Luncheon

The Maryland Congressional Delegation and a group of Med-Chi physicians concerned with legislation and MMPAC met recently for luncheon on Capitol Hill. The meeting provided a welcome opportunity for an exchange of views.

Dewitt E. DeLawter, MD, president-elect of the Faculty and MMPAC chairman, encouraged the physicians to join MMPAC representatives and legislative chairmen of local medical societies.

B. Martin Middleton, MD, state legislative chairman, spoke of the physician's image and stressed the concerns of doctors that are the same as those of all other consumers. He felt that legislators and physicians shared many characteristics, particularly that of objectivity. He invited the Congressmen to attend Peer Review and Utilization Review committee meetings at the Faculty office. Physicians are proud of Maryland's progress in these directions and would like all legislators to know how they work.

With specific regard to national health insurance, Dr. Middleton said he personally felt it would have to apply to all on a compulsory basis. He urged that drafters of any laws remember that what works in some other countries would not necessarily work in the United States. He mentioned these other essential points for a bill: free choice for the patient and for the provider of care, and adequate remuneration without prejudice for one type of care over another. The Medicredit Bill applies the fiscal burden to all as they can afford it rather than having the middle class pay the major costs as is often the case.

Senator Charles McC. Mathias, Jr. spoke briefly about the many advantages of this type of communication between legislators and their constituents.

Congressman Gilbert Gude called the attention of the group to the fact that he and representatives of the medical society in the 8th District have frequent luncheon meetings to discuss mutual concerns.

Representative Paul S. Sarbanes pointed out efforts being made in Baltimore towards improvement of health care delivery and said that it was most gratifying that in Maryland the relationship of the legislators and the medical society is so good.

Congressman William O. Mills mentioned that support of physicians is very important to politicians who may not attract much labor support.

Representative Goodloe E. Bryon stressed the importance to medicine of solo practitioners, especially in rural areas.

Congressman Lawrence J. Hogan reminded the group that he had introduced the first catastrophic illness legislation in his first term. He enlisted the help of the AMA in formulating its provisions. The bill is now known as the Muskie Bill and has grown so that Congressman Hogan scarcely recognizes it.

John C. Harvey, MD, spoke of the necessity of restraining hospital costs and of the importance of providing for pluralism or many different types of medical practice.

Philip F. Wagley, MD, urged the legislators to seek ways to provide individual care for the poor rather than institutional care. Due to rising costs it is now difficult to provide even institutional care.

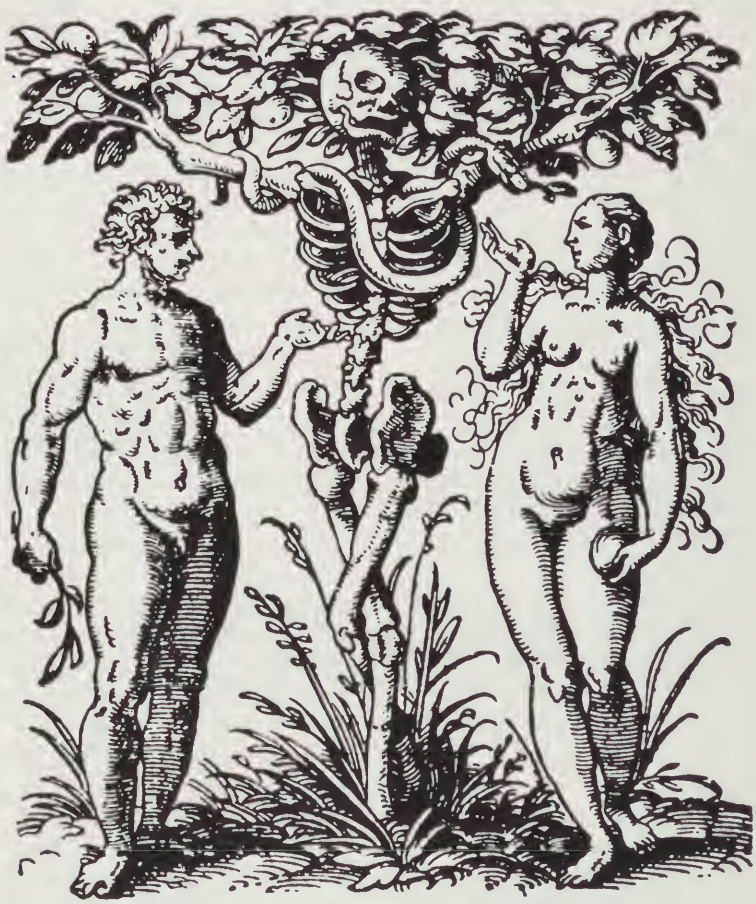
Senator J. Glenn Beall's legislative assistant, Joe Carter, called the attention of the group to the Senator's proposal for a National Institute of Health Care Delivery.

Louis L. Randall, MD, pointed out that individual physicians in small places often subsidize the care of the poor.

All of the doctors present were in agreement with the urgent necessity to increase medical school enrollment.

# In acute gonorrhea

## (urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



**Sterile Trobicin®**
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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**Warnings:** Antibiotics used to treat gonorrhea may mas delay the symptoms of incubating syphilis. Patients should carefully examined and monthly serological follow-up fo least 3 months should be instituted if the diagnosis of syphi suspected.

*Safety for use in infants, children and pregnant women has been established.*

**Precautions:** The usual precautions should be observed atopic individuals. Clinical effectiveness should be monitore detect evidence of development of resistance of *N. gonorrho*

**Adverse reactions:** The following reactions were obse during the single-dose clinical trials: soreness at the injection urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in no human volunteers, the following were noted: a decrease in he

# Trobicin®

## sterile spectinomycin dihydrochloride pentahydrate, Upjohn

## single-dose intramuscular treatment

**gh cure rate:* 96% of 571 males, 95% of 294 females**
osages, sites of infection, and criteria for diagnosis and cure are defined below.)**

**ssurance of a single-dose, physician-controlled treatment schedule**

**o allergic reactions occurred in patients with an alleged history of penicillin sensitivity hen treated with Trobicin, although penicillin antibody studies were not performed**

**ctive against most strains of Neisseria gonorrhoeae in vitro** (M.I.C. 7.5-20 mcg/ml)

**single two-gram injection produces peak serum concentrations averaging about 0 mcg/ml in one hour** (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

ote: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the mptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any fective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for onorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should e instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found persensitive to it.

ta compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-artin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-eatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the llow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined at reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or ilures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

bin; hematocrit and creatinine clearance; elevation of alka-e phosphatase, BUN and SGPT. In single and multiple-dose dies in normal volunteers, a reduction in urine output was ed. Extensive renal function studies demonstrated no con-ent changes indicative of renal toxicity.

**sage and administration:** Keep at 25°C and use within hours after reconstitution with diluent.

*ale*—single 2 gram dose (5 ml) intramuscularly. Patients with norrheal proctitis and patients being re-treated after failure previous antibiotic therapy should receive 4 grams (10 ml). In ographic areas where antibiotic resistance is known to be pre-lent, initial treatment with 4 grams (10 ml) intramuscularly is eferred.

*male*—single 4 gram dose (10 ml) intramuscularly.

**w supplied:** *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

*Susceptibility Powder*—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Human pharmacology:** Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

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# Book Reviews

**MEDICAL AMERICA IN THE NINETEENTH CENTURY, edited by Gert H. Brieger, The Johns Hopkins Press, Baltimore, 1972.**

This book consists of a series of papers that illuminate various aspects of the historical development of the medical profession and the commitment to public health in nineteenth century America. The author comments in the Preface that, ". . . many problems faced by students, practitioners, and patients of that day are still being discussed." Readings of the Faculty's Transactions often reveal that same observation. In fact many of the comments contained in such meeting minutes could be applicable to today's arguments and concerns. Nonetheless this book fills an important void in the present literature and is apparently part of a series dealing with medicine through current days.

**AUXILIARIES IN HEALTH CARE, Programs in Developing Countries, by N. R. E. Fendall, MD, The Johns Hopkins Press, Baltimore, 1972.**

Dr. Fendall has prepared his book with each chapter as a separate essay on a specific cadre of auxiliary in order to facilitate understanding of utilization within the framework of the major field of interest and activity. He states that, ". . . very few will need or desire to read the whole book." It is offered primarily to assist those closely involved with developing more extensive health measures—health planners and administrators.

**INCORPORATING THE PROFESSIONAL PRACTICE, by George E. Ray, Prentice-Hall, Inc., Englewood Cliffs, N.J. 1972.**

This book provides a practical and constructive approach to help the professional adopt the professional corporation as the form in which to carry on his professional practice. The book is directed to the professional and his advisors: lawyer, accountant, life underwriter, investment advisor, actuary, and trust officer, as well as the clinic or firm manager. It will serve as an easy primer on the whys and wherefores of professional corporations and is almost a must for the professional who has been undecided about whether to go this route or not.

**PATHOLOGY, Sixth Edition, by W. A. D. Anderson, MD, The C.V. Mosby Company, St. Louis, Mo., 1971.**

These two volumes represent a complete revision of previous editions. In addition to the rewritten chapters, there are many major changes in the discussions of various subjects. The author aptly states that, ". . . the basic nature of disease, and of medical practice, does not change. However, the extent and depth of our knowledge and understanding and of our conceptual and practical approaches are changing rapidly and no doubt will continue to do so." These volumes continue to be useful in the study of medicine as well as after, and do it well.

**MEDICAL PAPERS, NOTES AND LECTURES OF LOUIS A.M. KRAUSE, MD, 1917-1970; The Horn-Shafer Company Division of Geo. W. King Printing Company, 1972.**

This collection of various lectures, medical papers and notes of Dr. Krause is well worth reading. It is divided into two parts. Book One deals with Biblical-Medical matters, consisting of outlines, papers, notes, stories, and TV programs – all of historical interest.

Book Two is devoted solely to medical matters, including some case reports presented by Dr. Krause during his long years as a teacher. The foreword to this book consists of the data presented on the occasion of the 1963 Honor Award and Gold Key of the Medical Alumni Association to Dr. Krause, a 1917 graduate of the University of Maryland School of Medicine.

The tenor of these comments reflects the great esteem in which the author is held. In reading this book, it can easily and readily be seen why this is so. Dr. Krause has always epitomized the ultimate in a physician. This is exemplified from his many lectures and notes quoted verbatim in this publication.

We can only add our accolades to those quoted in 1963 . . . "Scientist, astute clinician, humanitarian, scholar, bibliophile, counselor, and friend, he exemplifies the highest ideals of the healing art. His contributions to science have been important, but above all, he has served his fellow man." It is fortunate that this material has been preserved in this manner for it will be used widely as a reference book and will be, we are sure, quoted from on innumerable occasions in the future.




*Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL,* 1211 *Cathedral Street, Baltimore, Md.* 21201.

# MEDICAL HELP SOUGHT

I am writing this letter in hope that somehow, in some remote way, I may find the help I need. My problem is one that has been caused by medical science. The story begins normally enough for a girl going through puberty. I developed an acne problem at a very young age, 11, and began seeing a dermatologist. After a number of years and no results — my condition only worsened — I began the rounds of doctors, only resulting in a gradual worsening of the problem. I went through every dermatological treatment of acne conceivable — soaps, lotions, surgical openings, antibiotic injections, dry ice, violet ray treatments, vitamins, diets, and always antibiotics.

This last, the antibiotics, is the real point where my story begins. It has now been established that for several years I have been getting severe infections that have developed from taking so many antibiotics through the years. Each antibiotic I tried — eurythremycin, tetracyclins, cleocin, and on and on — I would break right through after several weeks or several months or never respond to begin with. Every time an attempt was made to get me off the antibiotics, I would get too sick and the infections too severe to cope with. These infections consist of breaking out around the nose and mouth area, extreme inflammation of those areas, burning, swelling of the whole face, running a very high temperature (usually over 100°), white cell count that shot way up, tiredness, lack of appetite, general rundown and weakness, even chills and no ability to fight it off on my own, not to mention the severe pain involved. Each successive infection does not lessen, if anything, it gets worse. Presently, I am on ampicillin (usually one a day, 250 mg) which manages to control it while I am on it, at least to a limited extent, but the story is the same every time I go off — another severe infection. This is the problem — I must get off the antibiotics.

The doctors call this condition negative-gram (N-gram) folliculitis. I have been told by numerous doctors, all kinds — dermatologists, allergists, bacteriologists, general practitioners, gynecologists, internists, and even antibiotics experts —that nothing can be done. They have nothing to help me. Some have even refused to accept the fact that it is no longer a "simple" acne problem. Even birth control pills have not helped and no topical lotion that I have tried has been at all useful. My skin is usually too sore to even be touched. I have already developed one side effect, vaginitis, and dread the possibility of further complications.

I am willing to try anything, do anything, go anywhere, to get help. Any suggestions that you may have, or any interest you may take in this case, or any referrals you can make will be greatly appreciated. I have been told too often that this case is very rare and too insignificant to spend the time and money doing research on it. Yet I am plagued with this problem, and others probably have been in the past and no doubt there will be others in the future. How severe it will get no one knows; many have said I would outgrow it. Well, the problem has persisted for a good number of years and I am now 22. For over 11 years I have been receiving treatment of one kind or another only to end up at a desperate point with nowhere to turn. It is important that doctors in every field, researchers, and drug companies become aware of a problem like this. Possibly in this way, some hope or even an answer will be brought to light. If you have any information, new ideas or suggestions, please let me know. I will be only too glad to receive them and to cooperate. Thank you.

*(Name and address of this Pennsylvania woman will be supplied on request.)*

## THE KIDNEY DISEASE PROGRAM OF MARYLAND

On July 1, 1971 Senate Bill 778 became law. The Kidney Disease Program of Maryland was established which provided for the appointment of a Commission on Kidney Disease by the Governor of Maryland. The Commission is responsible for adopting standards for hemodialysis and renal homotransplantation centers; it is also charged with developing criteria for patient selection. Additional responsibilities include an educational program to bring information concerning prevention, diagnosis, and treatment of kidney disease to both the general public and the health professions.

The State Department of Health and Mental Hygiene is responsible for the actual administration of the program. The law provides for funding for patients requiring dialysis and/or transplantation by the State for amounts that exceed their third party coverage, Title XVIII or XIX, or other financing mechanisms. The patient may be required to make additional direct payment up to 5% of his gross adjusted income. This financing plan requires an annual appropriation from the legislature. The Kidney Disease Commission is required to make an annual report to the Governor.

The Commission is working with the Comprehensive Health Planning Agency to develop a State-wide plan to provide sufficient centers to care for all Maryland residents needing treatment. Because of the resource investment required to maintain these centers, duplication or poor utilization should be prevented.

Several hundred Maryland residents die each year from primary renal disease. Of these, 100 to 200 would benefit from dialysis and/or renal transplantation. At present less than 100 per year are being entered into treatment. The Commission is concerned with making treatment available and accessible to those patients with terminal irreversible renal disease who have medical indications for this treatment.

Since the Commission was established July 1971 it has been meeting regularly to review existing plans in other states, discuss needs in Maryland, and begin to develop standards. It is expected that the Kidney Disease Program will become operational in July 1972. Further details concerning the program are available from the Commission Office at 849 Eutaw St, Baltimore, Md 21201. Mr. Edward Green is the executive director and D. T. Lewers, MD, is chairman of the Commission.

EDWARD J. HINMAN, MD, MPH
Chairman, Education Committee
Maryland Commission on
Kidney Disease

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals

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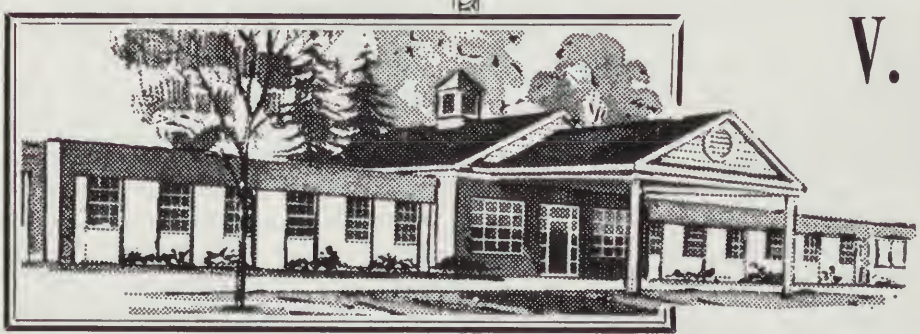
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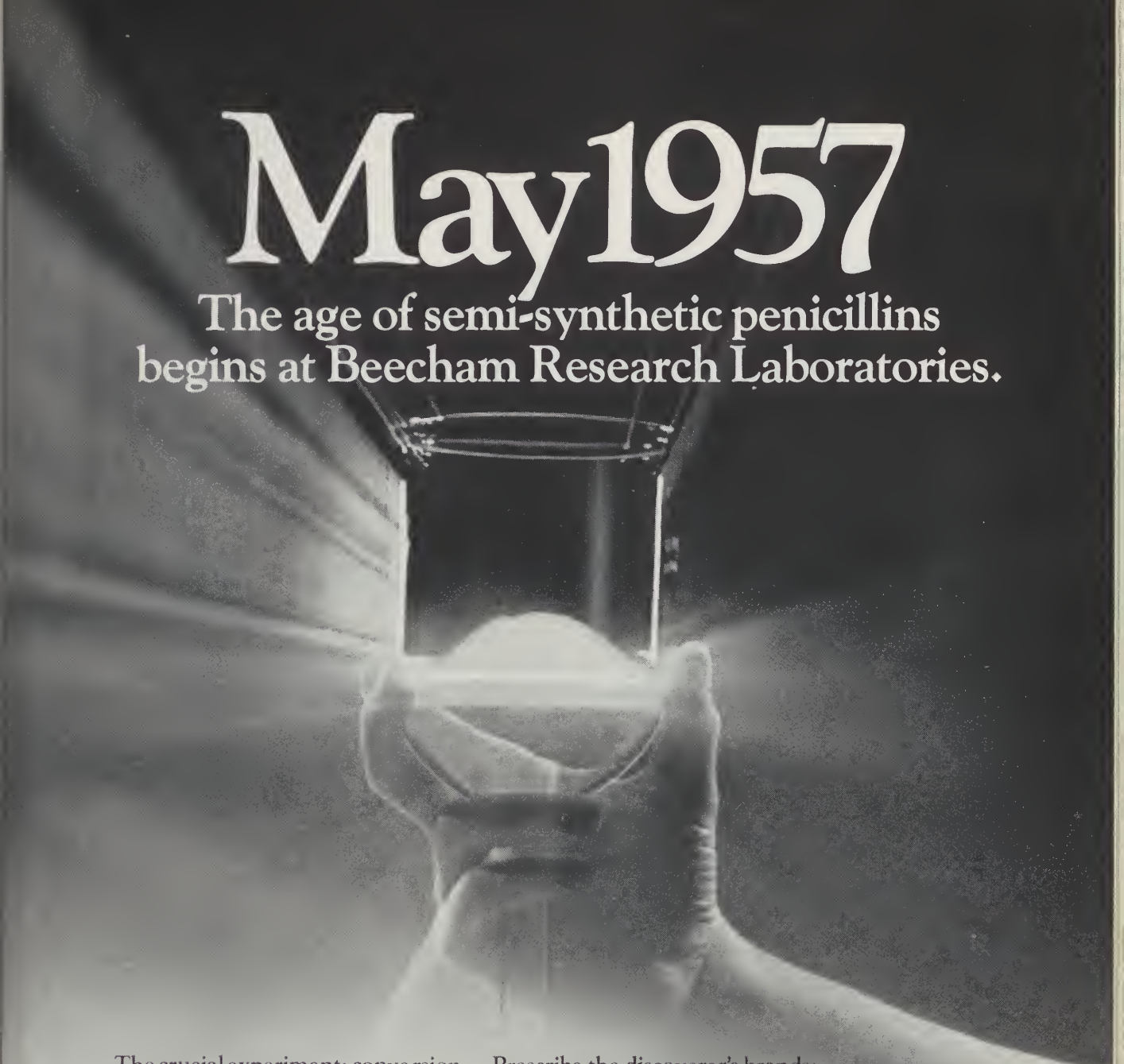
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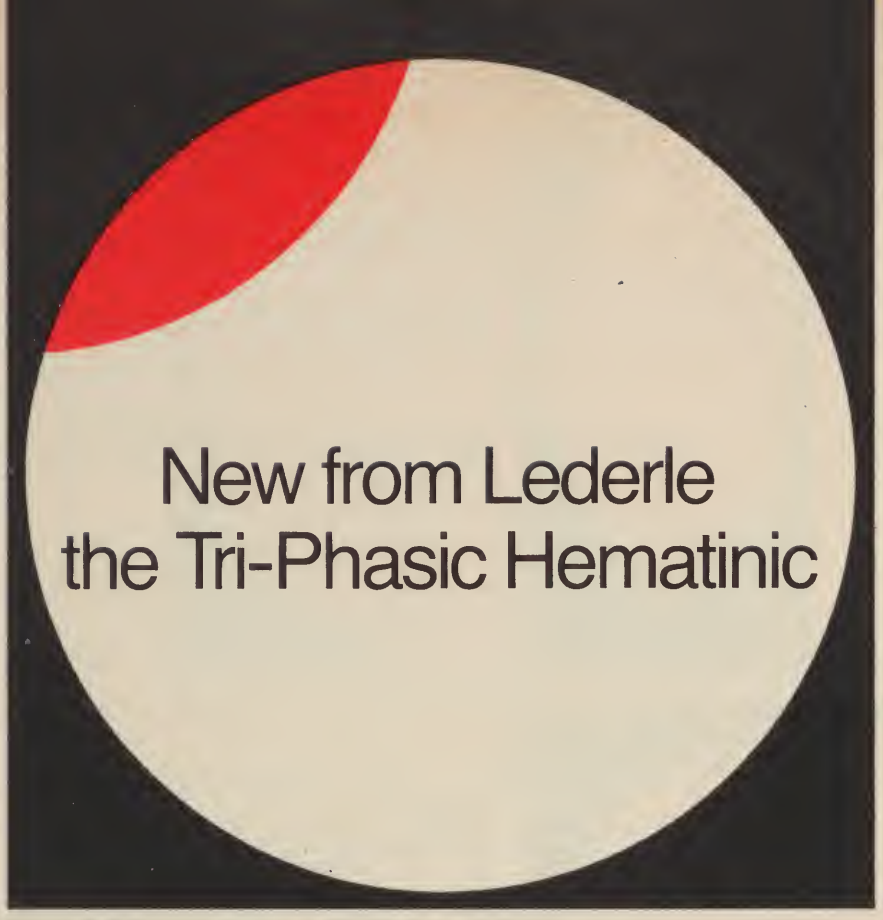
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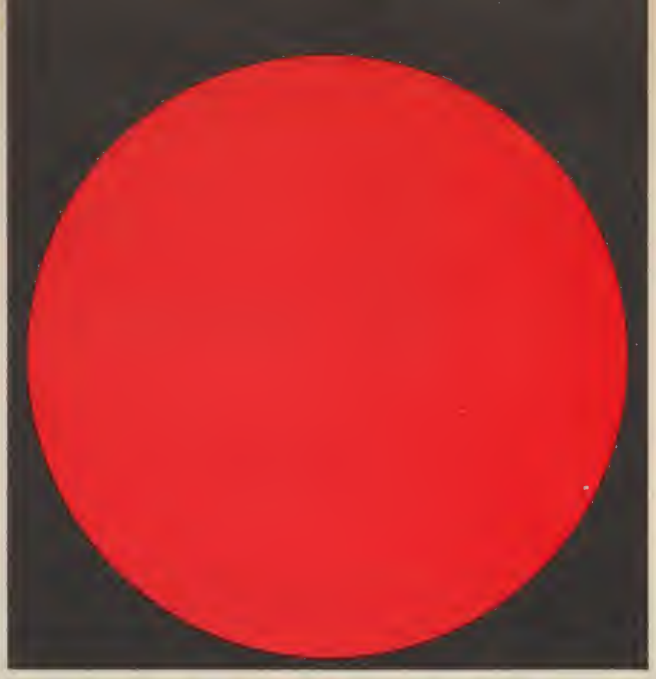
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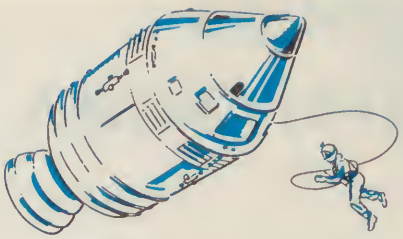
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**Precautions:** Use with caution when impaired rena hepatic function, severe allergy or bronchial asthm present. In glucose-6-phosphate dehydrogenase-defic individuals, hemolysis (frequently a dose-related r tion) may occur. Maintain adequate fluid intake to vent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocyt aplastic anemia, thrombocytopenia, leukopenia, he lytic anemia, purpura, hypoprothrombinemia, methe globinemia. *Allergic reactions:* Erythema multiforme vens-Johnson syndrome), generalized skin erupti epidermal necrolysis, urticaria, serum sickness, prur exfoliative dermatitis, anaphylactoid reactions, peri tal edema, conjunctival and scleral injection, photose tization, arthralgia, allergic myocarditis. *Gastrointes reactions:* Nausea, emesis, abdominal pains, hepa diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. r tions:* Headache, peripheral neuritis, mental depress convulsions, ataxia, hallucinations, tinnitus, vertigo somnia. *Miscellaneous reactions:* Drug fever, chills, t nephrosis with oliguria and anuria. Periarteritis no and L.E. phenomenon have occurred with sulfonam therapy. Sulfonamides bear certain chemical similar to some goitrogens, diuretics and oral hypoglyce agents. Goiter production, diuresis and hypoglyce have occurred rarely in patients receiving sulfonami Cross-sensitivity may exist with these agents.

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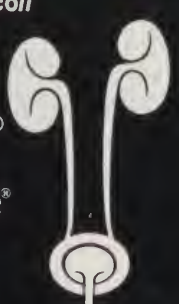
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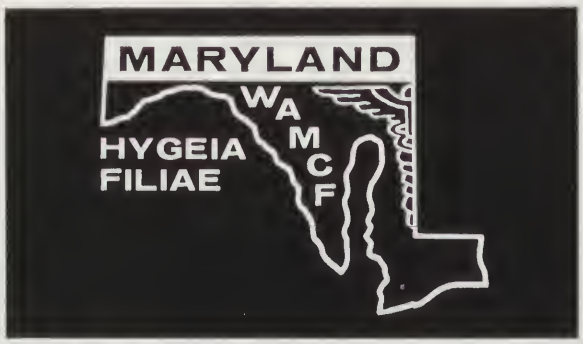
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MRS. WALLACE H. SADOWSKY, EDITOR

woman's auxiliary

# PRESIDENT'S ANNUAL REPORT, 1971-1972

The interesting, at times exciting, year that began unfolding in May 1971 is now filling in its final pages. No surprises were in store for us, but there were puzzles—puzzles for which we are still searching for answers. Before dealing with puzzles however let me express at once my deep gratitude for the loyal support given me by the Auxiliary Board and my firm conviction that no finer group of women exists. What a lucky president I was to be privileged to know and to work with these inspired doctors' wives. The burden of administrative detail was taken from me by the efficiency and kindness of Mrs. Anna Wynde Leake, who helped me through so many difficult occasions. And the problems attending the semiannual meeting in Puerto Rico were capably ironed out by Mrs. Genevieve Ritchie. To all these dedicated people I say "Thank you" from the bottom of my heart.

Outstanding memories include the warmth of welcome given me when I attended county meetings, the brilliance of the Caribbean setting for the semiannual meeting, the earnestness of the members attending the November workshops, the opportunity of hearing President Nixon speak to the doctors at the AMA Convention in Atlantic City in June, the fine impression Dr. Hall's inaugural address made upon me at his installation as AMA president, the chilled feeling I got from hearing HEW's Dr. Duval talk at the Southern Medical Convention in Miami, the work of Dr. and Mrs. Williams for the needy hospital in Honduras, the unremitting effort of Mrs. Gruss for the Tea for the Wives of Foreign Interns, the boundless enthusiasm with which Mrs. Linhardt has projected AMAERF.

But the highlight of them all had to be the night the Pittsburgh Pirates won the pennant! The Eastern Region Workshops were due to begin in Pittsburgh at the Hilton Hotel the day following the game and we who attended the workshops left Baltimore on a flight just ahead of the victorious Pirates and flew right into a victory-happy mob lining both sides of the highway from the airport into Pittsburgh. So thoroughly did they clog the road that the airport bus could move but inches at a time and it finally came to a stop in the middle of the bridge over the Monongahela River. The impatient mob, clamoring for their Pirates, released a little energy by beating on the bus. The crowd on the other side did likewise, and presently the heavy bus was swaying back and forth like a toy, while the passengers held their collective breaths waiting for the inevitable toppling into the torrent below.

The inevitable didn't happen though. As in the movies, just when the swaying reached a dangerous pitch, a great shout of "Here they come!" diverted the mob and our driver was able to get going and get off the bridge before the mob discovered it was a false alarm and the Pirates hadn't come at all. We were hours reaching the hotel and once there it was another whole hour to push from the entrance through the lobby to the reservations desk, the throng being so tightly packed that one moved helplessly whichever way the crowd moved. The doors to the restaurant, coffee shop, and restrooms were closed and locked; the elevators were roped off and protected by armed guards; and an urgent voice over the loudspeaker kept repeating, with no effect at all: "Go home. Go home. The Pirates are not coming here." Outside, bonfires were being lit in the streets and cars were being overturned. Quite an introduction to the workshops, which somehow seemed a little drab after the colorful night.

The director of the Council on International Relations expressed to Mrs. Gruss, chairman of our International Health Activities Committee, the need for some social activity for the wives of foreign interns. Mrs. Gruss suggested that perhaps a reception or tea sponsored by the

Med-Chi Auxiliary would bring together these wives from far away and provide them with a pleasant afternoon. A great deal of planning and work went into the arrangements. The most difficult problem was contacting the prospective guests. On February 22, 1972, at Osler Hall, Mrs. Gruss had a beautifully appointed tea table with dainty sandwiches and trays of delectable tea cakes. She served wine as well as tea and all who came were delighted. She had also made plans to take care of any children who might come, as she felt that some mothers might have a problem with baby sitters. Of very great interest to me were the comments of some Volunteer Services personnel, a number of whom attended from the various area hospitals. The comments went like this: "We have felt the need for such an affair for foreign wives. We have wanted to do something, but we didn't know what and we didn't know how. So we were very glad to come and see what you were doing."

Membership files show the Auxiliary accepted 88 new members; unhappily, we received 31 resignations. We have an exciting prospect ahead though. Mrs. Alvarez, our Members-At-Large chairman, reports the possible formation of a new component auxiliary. At this writing, Anne Arundel County is to meet soon to form an auxiliary. A constitution has been drawn up for their consideration; hopefully, by the time of our annual meeting on May 4, we will have a 12th component auxiliary.

To return now to the puzzles I mentioned at the beginning of this report, the most troubling is the unwillingness of so many members to serve as officers. We have a number of very capable members. Why are we failing to interest them in serving? We must find an answer if we are to continue to exist as an Auxiliary.

Why are so many of the younger doctors' wives not joining the Auxiliary? How can we change to be in keeping with the times and gain their interest?

How is the entrance of government into health activities going to affect us? It has already made a difference with the high school health careers clubs which we sponsor.

What is the cause of the lowering of the image of the doctor in the public esteem? What can the Auxiliary do to help reverse this trend?

These are some of the puzzles that must be solved. I suggest that a committee made up of an active member from each county be appointed to meet at stated intervals for a specific number of meetings to "brainstorm" these questions and see what answers can be found.

However the incoming president is going to come up with some interesting answers herself. She is a young woman with imaginative ideas and the know-how to put them to use. Knowing Caryl Kolkin has been a delight. She was with me that dreadful night in Pittsburgh, and I assure you she keeps her "cool"!

This has been a wonderful year with wonderful people and I am honored to have been the president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. Thank you all.

PAULINE L. REITER
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# JOHN CRAWFORD MANUSCRIPT

One of the unpublished treasures of the Med-Chi Faculty Library is a manuscript volume by one of Baltimore's most famous physicians, John Crawford (1746-1813). This small quarto, written about 1796, contains "A Letter addressed to Lieutena't (!) General Mathew On the means of preventing, the method of treating, and the origin of the Diseases most prevalent and which prove most destructive to the Natives of Cold Climates visiting or residing in Warm Countries." The "Letter" covers the rectos of 176 leaves, each containing about 25 lines of a fine, clear holograph apparently in Crawford's hand.

The manuscript has been cited by Julia E. Wilson in "An Early Baltimore Physician and His Medical Library" (**Annals of Medical History, 3d** Series, 4, January 1942, 63-80). Earlier, in another article about Crawford (**Bulletin of the School of Medicine, University of Maryland, 25,** no. 2, October 1940, 116-32), Miss Wilson culled from the manuscript Crawford's comments proposing the establishment of a botanical garden.

But there is considerably more information to be gathered from this unique volume which is based on nearly 30 years of medical experience in warm climates. In his introductory remarks Crawford anticipates some of the generalities of the phenomenon of natural selection, the influence of climate on health and disease, and the varieties of diet among nations: "The French are remarkable for their inventions in the art of cookery, and have by these debauched themselves, and all that come within their influence (p. 12). I believe indigestion is one of the maladies most prevalent amongst that People . . . (**ibid.**)."

We note Crawford's interesting observation that "The advantages the Negroes and Mulattoes possess, in seldom falling a sacrifice to the ardent fevers which prove so fatal to Europeans in a similar situation, is well known to all who have had an opportunity of making the comparison. I scarcely know an instance of death having happened among them, from such a cause. It is however not a little singular, that during the late plague at Philadelphia, the Negroes did not experience the same immunity as on former occasions in a like case. It would be curious and instructive to ascertain whether their habits of living have undergone a material change since their emancipation from slavery? If they live better as it is called, than formerly, and indulge more in excess, the advantages of temperance would be conclusive" (p. 16-17).

Obviously a text as cogent and calculating as this one, filled with comments on foodstuffs, on the quality of wines and spiritous liquors, and the devices of diet, deserves to be examined by a worthy, able student.

Although the volume was presented to Med-Chi by Dr. John Wesley Chambers who was active in Med-Chi at the end of the 19th century, the book was inappropriately cataloged as "Miscellaneous ms. articles. n.d.," and had been missing in the Library's collection for a decade (according to an inventory note). It has been found again though, through the Library's weeding project, and it is now properly cataloged: Crawford, John. **A letter . . .** (see above). Baltimore? 1796? We hope that it will be studied and eventually published, perhaps under the auspices of the Library's History and Rare Books Section where it is now safely housed.

LEE ASH
Library Consultant

# WILLIAMS AND WILKINS VS THE UNITED STATES

On February 16 Commissioner James F. Davis of the United States Court of Claims issued an opinion sustaining the claim of the Williams and Wilkins Company for copyright infringement resulting from the unauthorized reproduction of copyrighted materials on photocopying machines in certain Government libraries. If adopted, the Commissioner's report would affect the photocopy programs of all libraries.

The Commissioner's Report does not have the effect of law, unless the judges of the Court of Claims uphold it. Government attorneys plan to file an exception to the Commissioner's Report, and a decision by the Court of Claims is still some time away. This is the first copyright case to reach trial in the Court of Claims, and its ruling will undoubtedly be appealed. The final decision may well rest with the Supreme Court of the United States.

The American Library Association, the Association of Research Libraries, and the Medical Library Association have issued consistent statements regarding the Commissioner's Report. Libraries are reminded that the Report does not have the effect of law, and that the decision and appeal procedures are long and time consuming. Until the final decision is reached, libraries are advised to continue existing policies and practices with respect to photocopying of copyrighted materials. Accordingly the library of the Medical and Chirurgical Faculty does not plan to change its Xeroxing policies as a result of the Commissioner's opinion at the present time.

## NEW ACCESSIONS - BOOKS
Arranged by Subjects

ANESTHESIA

WO 240 .H5 — Hill, Dennis Walter. **Electronic measurement techniques in anaesthesia and surgery.** New York, Appleton-Century-Crofts, 1970.

BIOCHEMISTRY

QV 135 .R6 — **The role of adenyl cyclase and cyclic 3′, 5′-AMP in biological systems.** A colloquium sponsored by the John E. Fogarty International Center for Advanced Study in the Health Sciences, National Institutes of Health, November 17-19, 1969. Theodore W. Roll, Martin Rodbell and Peter Condliffe, scientific editors. Bethesda, Md., National Institutes of Health, 1971.

BIOLOGY

QH 605 .P7 — Priest, Jean H. **Cytogenetics.** Philadelphia, Lea & Febiger, 1969. (Medical technology series)

Z 695.1 .N9 .T6 — Todhunter, E. Neige. **A guide to nutrition terminology for indexing and retrieval.** Bethesda, Md., National Institutes of Health, 1970.

CARDIOVASCULAR SYSTEM

WG 102 .K4 — Kelman, George R. **Applied cardiovascular physiology.** London, Butterworths, 1971.

WG 100 .N2 1969 — U.S. National Heart Institute. Diet-Heart Review Panel. **Mass field trials of the diet-heart question:** their significance, timeliness, feasibility and applicability; an assessment of seven proposed experimental designs. New York, American Heart Association, 1969. (Am. Heart Assoc. Monograph no. 28)

CENTRAL NERVOUS SYSTEM

WL 344 B2 — **Background to migraine,** Vols. 2 & 3. New York, Springer. (Proceedings of the 2d and 3d Migraine Symposium. Sponsored by the Migraine Trust)

WL 355 .F5 — Fields, William Strauss. **Stroke rehabilitation;** basic concepts and research trends. Compiled and edited by William S. Fields and William A. Spencer. St. Louis, W. H. Green, 1967.

CLINICAL PATHOLOGY

QY 21 .W5 — Williams, Margaret Ruth. **An introduction to the profession of medical technology.** Philadelphia, Lea & Febiger, 1971.

ENDOCRINE SYSTEM

WK 818 .G6 — Gormican, Annette. **Controlling diabetes with diet.** With drawings by Pat Lenihan. Forewords by Edgar Gordon and Donnell Etzwiler. Springfield, Thomas, 1971.

FERTILITY

WP 630 .N57 — Nobel Symposium, 15th, Lidingo, Sweden, 1970. **Control of human fertility.** Edited by Egon Diczfalusy and Ulf Borell. Stockholm, Almqvist & Wiksell; New York, Wiley Interscience Division, 1971.

GERIATRICS

WT 27 .AN6 .T4 — Thomas, William C. **Nursing homes and public policy;** drift and decision in New York State. Ithaca, N.Y., Cornell University Press, 1969.

WT 30 .U6 — U.S. Congress. Senate. Special Committee on Aging. **Developments in aging, 1970;** a report, pursuant to S. Res. 316, Feb. 16, 1970, resolution authorizing a study of the problems of the aged and aging, together with minority views. Washington, U.S. Govt. Print. Off., 1971.

HEALTH ADMINISTRATION AND ORGANIZATION

WA 540 .A .P8 — U.S. Public Health Service **Public health service grants and awards,** fiscal year 1968 funds. Washington, U.S. Department of Health, Education, and Welfare, Public Health Service, 1968.

INFECTIOUS DISEASES

WC 200 .I6 — International Conference on Nosocomial Infections, Center for Disease Control, 1970. **Proceedings.** Chicago, American Hospital Association, 1971.

MEDICAL PROFESSION

Ref. W 20 A5 — American Medical Association **Directory of approved internships and residencies, 1971-1972.**

W 50 .06 — **Opinions and Reports of the Judicial Council,** 1960, 1964, 1969, 1971. Chicago, American Medical Association.

MEDICAL SERVICE PLANS

W 275 .AM5 .W4 — Weeks, Lewis E. **The complete gamut of progressive patient care in a community hospital.** Battle Creek, Mich., W. K. Kellogg Foundation, 1967.

METABOLIC DISEASES

WD 220 .F5 — Filley, Giles Franklin **Acid-base and blood gas regulation.** Philadelphia, Lea & Febiger, 1971.

MUSCULOSKELETAL SYSTEM

WE 168 .S4 — Shands, Alfred Rives **Shands' Handbook of orthopaedic surgery.** By R. Beverly Raney and H. Robert Brashear, with the collaboration of Alfred R. Shands, Jr. 8th ed. St. Louis, Mosby, 1971.

NERVOUS SYSTEM

WL 100 .E5 — Elliott, Frank A. **Clinical neurology.** 2d ed. Philadelphia, Saunders, 1971.

PATHOLOGY

QZ 4 .B6 — Boyd, William **An introduction to the study of disease.** 6th ed., thoroughly revised. Philadelphia, Lea & Febiger, 1971.

PEDIATRICS

WS 420 .S3 — Schaffer, Alexander J. **Diseases of the newborn.** By Alexander J. Schaffer and Mary Ellen Avery. With a section on neonatal cardiology by Milton Markowitz and with a section on fluid and electrolyte therapy by Laurence Finberg. 3d ed. Philadelphia, Saunders, 1971.

WS 100 Y4 — **Year Book of pediatrics.** Chicago, Year Book Medical Publishers, 1972.

PERIPHERAL NERVOUS SYSTEM

WL 500 .W4 — Woodhall, Barnes **Peripheral nerve regeneration,** a follow-up study of 3,656 World War II injuries. Editors: Barnes Woodhall and Gilbert W. Beebe. Washington, U.S. Govt. Print. Off., 1956.

PHYSIOLOGY

QT 260 .N3 — National Athletic Trainers Association **Fundamentals of athletic training;** a joint project of the National Athletic Trainers Association, the Athletic Institute, and the Medical Aspects of Sports Committee of the American Medical Association. Chicago, American Medical Association, 1971.

QV 38 .H3 — Hansten, Philip D. **Drug interactions;** clinical significance of drug-drug interactions and drug effects on clinical laboratory results. Philadelphia, Lea & Febiger, 1971.

PLASTIC SURGERY

WO 600 Y4 — **The Year book of plastic and reconstructive surgery.** Chicago, Year Book Medical Publishers, 1972.

PSYCHOLOGY

BF 531 .E5 — **The Emotions.** By Carl Georg Lange and William James. New York, Hafner Pub. Co., 1967.

PSYCHIATRY

WM 30 .N2 — National Institute of Mental Health **Staffing patterns in mental health facilities, 1968.** Washington, U.S. Govt. Print. Off., 1970. (Mental Health Statistics. Series B, no. 2)

RADIOLOGY

WN 620 .S9 — Symposium on the Biological Effects and Health Implications of Microwave Radiation, Richmond, 1969. **Biological effects and health implications of microwave radiation;** symposium proceedings. Edited by Stephen F. Cleary. Available from the Clearinghouse for Federal Scientific & Technical Information, Springfield, Va., 1971.

WN 100 Y4 — **Year book of radiology.** Chicago, Year Book Medical Publishers, 1972.



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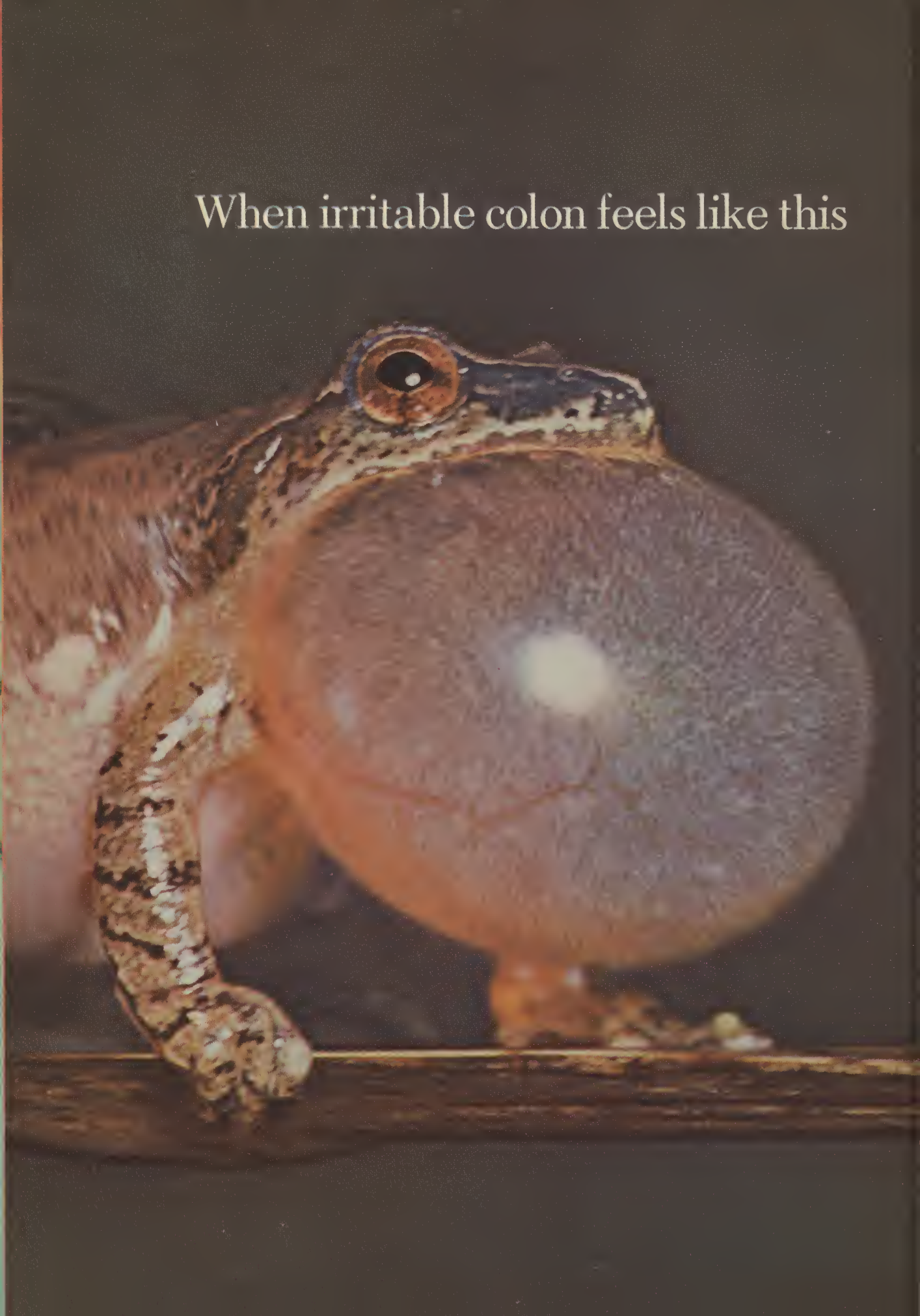
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# The Revolutionary War and its Effect on Medicine in Maryland

DOUGLAS CARROLL, MD
Baltimore City Hospitals
Baltimore

*This is the fourth of a ten-part series of articles on the history of medicine in Maryland from 1634 to 1835 written by Dr. Carroll. Others will appear in future issues.*

> ***"The war experience conferred benefits upon medical men associated with the Army not only by giving them many new cases to handle, but also by exposing them to techniques and systems of medicine that were better than they had previously known . . . . . in 1782 (the chief physician of Rochambeau's army, Jean-Francois Coste) asserted that as the United States was now independent, medicine in the country must be free from subjection to authority, even of the most celebrated master."***
>
> ***Brooke Hindle: The Pursuit of Science in Revolutionary America, 1956***

Prior to the Revolutionary War, the colonies had little experience with military medicine and hospitals. During the French and Indian War, the British brought their own army physicians and hospitals. These hospitals were well organized and had experienced doctors. Such military hospitals were set up at Fort Frederick and Fort Cumberland.[1] Their tables of organization, complement, pay scale,[2,3] and number of sick[4] are all available because of an investigation of the hospitals by the General Assembly of Maryland in 1752. Supplies were obtained through an agent[2] and the Colony of Maryland paid the British for medical care of Maryland soldiers.[5,6] Thus, with the coming of the Revolutionary War. Maryland, like the other colonies, had few experienced military physicians, no supplies, supply system, or plan as to how to organize a military medical system. The result was that the hospitals were given low priority and never achieved even the efficiency of the army.

### C.F. Wiesenthal and James Murray

Charles Frederick Wiesenthal (1726-1789) had some experience in the Prussian Army prior to emigration to Baltimore in 1755. There is a family tradition that he was "physician to Frederick the Great."[7] He was naturalized in 1771 and was involved in the Revolutionary cause from the beginning. In addition to duties on the Committee of Observation of Baltimore County and procurer of saltpetre for Maryland, he also performed military medical duties. In March of 1776 he was commissioned Surgeon Major of the 1st Maryland Battalion. Later he had supervision of army medical matters in Baltimore, establishing and running the hospital, procuring medical supplies, and examining and placing physicians in the service, as well as caring for soldiers. He did not serve with troops outside the state.[8]

As early as 1770,[8] he outlined for the Council the table of organization of the Army Medical Departments in the Prussian and English Army, giving the ratio of surgeons, surgeon mates, surgeon majors, and surgeon generals assigned to companies (one surgeon per 160 men), battalions (one surgeon and one surgeon's mate), and regiments (a surgeon-major in addition), and above (a surgeon general in addition).

He was active in Maryland military medical affairs until the end of the war. In 1776 he presented a short dissertation on types of military hospitals (garrison, flying, and fixed) to the Council. He was intimately involved in supplying

the military hospital at Baltimore,[9] was called on to evaluate the quality of drugs being purchased,[10] and to produce almost nonexistent medical materials on short notice.[11] In 1777 he was made Surgeon-General of Maryland Troops.

In 1781[12] he rather plaintively notes the deficiencies of medicines in the hospitals. There have been no supplies in from the Continent recently. He requests cash to repay various people who have furnished him in the past. A few days later (7/31/1781), he has been able to obtain a set of amputating instruments from an unknown source.[13] Dr. Wiesenthal was the most prominent Baltimore practitioner of the time, and also played a larger and more important part in the local military medical affairs than any other physician.

James Murray (1739-1819) of Annapolis was probably the second most important physician who continued his practice during the Revolutionary War and contributed to the military medical needs of Maryland. The Annapolis Hospital was in existence in 1776,[8] and had a number of physicians associated with it. James Murray became physician to the Annapolis Hospital early in 1780[14] and remained in charge until its dissolution about December 1783.[15] In addition he had charge of the Maryland medical supply store at Annapolis, and was inundated with special orders. Murray appears to have been well respected in the community as well as by the soldiers. In 1780, Uriah Forrest, a line officer in the Continental Army, requests Governor Lee for care of 20 to 30 Continental soldiers in the Annapolis Hospital. He recommends Dr. Murray who "has done a good job and can be got to attend them on less expensive terms."[16]

Charles Wiesenthal was paid 35 shillings a day with no rations;[7] Murray received about 30 pounds a month.[17] In addition they presumably carried on a private practice and other public services. James Craik, Chief Physician of the Continental Army Hospital Department, appears to have been paid, at least for the year 1780, by the State of Maryland. The paymaster (1/25/1780) was directed to supply James Craik a suit of clothes and linen for four shirts for the year 1780.[18] Dr. Nathan Brownson, Purveyor of the Southern Hospital (in the Southern Campaign District), was paid in specie and Spanish sugar.[19]

Young doctors wishing to enter the military service often asked influential doctors to write recommendations for them and were sometimes appointed by the Legislature rather than the Military.[20]

Daniel Jenifer of Port Tobacco, writing 10/11/1781, requests a position for a Dr. Harrison, who was a colleague or student of Jenifer's physician son. A position was requested as Regimental Surgeon or "interne of the hospital, the latter he would prefer."[21]

Both allied and enemy physicians were treated with consideration. In 1782 Mour Coste, First Physician of the French Army, is thanked politely for his care of American convalescents.[22] Dr. Robert Smith of His Britannic Majesty's General Hospital, having given his parole to stay in Annapolis, was given permission to go to Baltimore to arrange supplies for sick German (Hessian) soldiers in Frederick.[23] A possible local traitor, Dr. Thomas Wright, however, was declared dangerous to the State, and was bonded for 500 pounds of gold.[24]

## Military Hospitals in Maryland

The State Military Hospitals in Maryland were generally directed by local practicing physicians. They were assisted, somewhat irregularly, by military surgeons and surgeon mates, when these were available from line outfits. Wiesenthal, writing the Council of Maryland on 4/10/1776,[25] notes that he had been attending all soldiers in the Baltimore hospital since the middle of February, helped for short periods only by Mr. William Augustus Dashiell, Mr. Nathan Dorsey, and Doctors Budd, Coulter, and Beard. These doctors were all associated with the ship *Defence* and apparently helped Wiesenthal for only very short periods of shore duty.

The Military Medical Hospital in Baltimore was the busiest of the Maryland hospitals during the Revolutionary War. There were always shortages. On 1/29/1777 the Continental Congress passed a resolution recommending that Dr. Samuel McKenzie "who has the care of the sick in the hospital at Baltimore be empowered to employ a mate."[26] A few days later he was allowed repayment of funds for medicines. On 2/20/1777 the Assembly of Maryland was requested to deliver to McKenzie enough drugs to innoculate 100 soldiers: Three oz calomel, two lb of jallop, three lb of nitre, elixir vitriol, one lb of Peruvian bark, and one lb of Virginia snake root.

Another prominent Maryland physician to serve in the Baltimore Hospital in 1776 was John Coulter, an Irishman who came to Baltimore in 1773, served in the Continental Navy on board the *Defence*, and practiced in Baltimore for many years after the war.

The military hospital in Annapolis was second in size to the Baltimore hospital. Dr. Richard Tootell, in a plaintive letter (8/17/1776), states that he has given faithful service to the hospital. When he took the job, he did not expect that he

would not only have to treat the sick, but also to obtain supplies and medicines. He has been asked recently to go with his unit into the field, but he begs off because he never expected that his battalion would leave Annapolis. He cannot leave Annapolis because of his age, bad health, and family. Furthermore he would have to give up the income from his private practice, amounting to three to four hundred pounds per year.[27]

The results of the doctor's refusing to join the field units is suggested by a letter to the Council of Maryland on 9/14/1776 from J. A. Thomas, a line officer. Two hundred Maryland soldiers are unfit for duty in the encampment at Harlem, New York. There are only two Maryland surgeons with the troops and one of these is sick. Thomas is unable to get any assistance for the care of his sick soldiers. He points out how such poor medical care discourages enlistment in the army.[28]

In 1782 Dr. Philip Thomas of Frederick requested that a hospital be erected in Frederick. The Council answered that Thomas could go ahead if absolutely necessary to erect a hospital using local timber. If it could be delayed, he was directed to request materials through the minister of the War Department.[29]

We have one illustration of how hospitals were located during campaigns. In 1782 an effort was made to defend the Chesapeake Bay using barges. Capt. Zedekiah Walley was directed to locate his magazines at Snow Hill. "As for the Hospital, that must be fixed at such a place as the Doctor, with your concurrence shall judge most convenient."[30]

Hospitals were discontinued precipitously at the end of the war. The Council wrote Dr. James Murray on 12/24/1783: "As the Continental Army is disbanded and the United States will not pay any expenses created after this period, we think it necessary to inform you we intend to break up the hospital near this city, and that your attendance as physician is therefore to cease from date thereof."[15]

Most of the soldiers admitted to the Maryland military hospitals were chronically ill. Forest requests admission of 20 to 30 soldiers needing physicians on 5/15/1780. One half had "triffling" illnesses; 14 were exceedingly ill, needing diagnosis and treatment by a physician, fresh provisions and attentive care. Epidemics in the hospitals were common,[31] and made the regimental surgeons loath to transfer their wounded.

The major supplies needed by the local hospitals.[42] Because of a dangerous fever among the meat,[33] and wine.[34] Beds, chamberpots, porringers, blankets, sheets,[35] and clothes for patients were all in short supply. Gen. Moses Hazen at Head of Elk reported that the sick men of his command in the Annapolis Hospital were in great want of clothes. He requests that these patients be returned to him when a hospital is established at Head of the Elk.[36]

On one occasion in 1781 the State Armorer was directed to make 20 bunks for sick soldiers in the Annapolis Hospital.[37]

Hospitalization was requested for some French soldiers from the vessel *Neskit* by Lafayette through Dr. James McHenry in 1781.[38] Some civilians were admitted to the Annapolis Hospital,[39] and chronically ill discharged veterans were given special consideration.[40,41]

Private houses were used temporarily as hospitals.[42] Because of a dangerous fever among the troops in August 1781, the Anne Arundel Almshouse was taken over for soldiers,[43] and the poor were moved into a private house, rented for the purpose. There were soldiers still in the Almshouse six months later.[44] A few months later, it is noted that the wives of invalids and soldiers are occupying quarters needed for effective soldiers. Room in the Almshouse was found for the sick.[45]

## Drug Supplies

It was clearly recognized by Colonial military physicians that, in Charles Wiesenthal's words, infection was the greatest "havock of armies."[25] The only treatment was isolation of the infected from the well in hospitals. Dr. Philip Thomas reported 50 soldiers with smallpox, measles and putrid remittent fever "which is said to be contagious" in Frederick in 1781.[46] The men who tried to supply the Medical Department with medical supplies (Charles Wiesenthal in Baltimore, James Murray in Annapolis, and Philip Thomas in Frederick) were never able to fulfill their obligations. Nearly all supplies had to come from Europe and the Barbados, and Great Britain's naval supremacy made this difficult. Even fresh food and flannel for bandages were in short supply.

Cream of tartar was one of the medicines most in demand.[47,48] Jesuits' Bark was used extensively.[49-51] Robert Smith, an agent in Havana, reported to Gov. Lee on 6/30/1781 that he could not find even inferior Jesuits' Bark at four dollars a pound.[52] Jalop[53] and opium[54] were also always in short supply. An amusing mix-up resulted in the delivery to Baltimore of a hogshead of medical supplies ordered by Dr. Thomas Bond of Philadelphia, who located the lost cargo, claimed it, and received it. This hogshead contained camphor, cream of tartar, Ipecacuanha, opium,

aloes, tartar emetic, Sal. Saturnus, red precipitate, fol. Senna, Coros Mercury, and Copenhagen rhubarb.[55]

Pocket and amputating instruments were also in demand. Occasionally, troop movements were help up awaiting a medical chest.[56,57] One unwary naval doctor neglected to take his personal medical chest ashore. It was promptly sold to the state, but finally returned to the rightful owner.[58]

The French brought their own medical supplies with them and were occasionally able to spare some for the Maryland hospitals.[59]

* * * * *

The pattern of military medical care in Maryland was similar to that of the other colonies in the war zone. The medical corps was dependent on volunteers. Physicians were exempt from military service,[60] and local doctors cared for the wounded in their immediate neighborhood. Even local doctors assigned to particular regiments often did not accompany their units into other states.[8,27] This resulted in poor medical care in the field[28] and overcharging by doctors at home. The legislatures were not able to correct the deficiencies adequately. Examination boards for doctors applying for service were superior to no control at all, but were deficient in testing the actual performance under battlefield conditions.

Other difficulties with obtaining army surgeons were the low pay, the uncomfortable life, and the lack of real military rank. The most efficient and effective part of the military medical system seems to have been the general hospitals, fixed in a town, run at least partially by local practitioners, supplied from state stores, and dealing largely with chronic injuries—except when swept by an epidemic of smallpox, typhus, or other infectious diseases.

## Maryland Physicians in the Revolutionary War

Berkley[61] lists 188 physicians in Maryland between 1775 and 1783. Some of these were Maryland born but did not practice in Maryland. Others are mere names of men who are thought to have been physicians. One, Dr. Edward Johnson, may have been a chemist. One died in 1755 (Dr. Charles Carroll). The list, in brief, is incomplete and not entirely trustworthy. Nevertheless a number of interesting facts about participation of physicians in the Revolutionary War can be gleaned from the list.

About 70 of the 188 physicians served as regimental and company surgeons, largely with the Maryland line troops. A few served in the Navy. At least 24 men started out as a surgeon's mate and were promoted to surgeons. Three were wounded. Examinations for medical competence were not given until late in the war.

At least 12 physicians remained in practice and had little or no involvement with the war effort.[60] The majority of physicians however were involved in some way with the war effort; 11 served as physicians for local militia; and 16 served on Committees of Safety, Committees of Correspondence, or other public bodies.

About 11 physicians were in the hospital service rather than line outfits. Three local practitioners ran smallpox innoculation hospitals for the troops. Gustavus Brown (1748-1804) ran such a hospital at Port Tobacco, Prince George's County. James Murray (1739-1819) and Richard Tootell served as innoculation surgeons at the Annapolis Hospital. Others were assigned as hospital physicians to military hospitals in Port Tobacco, Annapolis, and Baltimore. A number of physicians served as line or staff officers; James McHenry (1753-1816) becoming aide to General Washington in 1778, and later Secretary of War (1796-1800). Josias Carvell Hall (1746-1814) reached the rank of Colonel in the Infantry. One physician filled in as chaplain to his company.

There are very few primary records of Maryland regimental surgeons available. A letter from Dr. Richard Pindell in 1781 reveals some of the problems of military medical practice at the front.[62] Richard Pindell (1755-1833), born in Hagerstown, served in the Revolution from January 1, 1777 to 1783. His education is unknown, but he came into the army at age 22 and was made a full surgeon in the following year in the First Maryland Regiment under Col. Otho Holland Williams. He was with General Greene in 1780 and 1781. A letter written at Charlotte on May 26, 1781 reveals some of the practices and problems of the Southern Army.

The letter is directed to Col. Otho H. Williams and concerns the amputation of the arm of Lt. Col. Benjamin Foard of Smallwood's regiment. Foard was wounded in the arm at Hobkirk's Hill on April 25, 1781. Apparently the wound became infected and abscesses formed. Foard refused drainage. The bone became exposed and osteomyelitis resulted. About a month after the wound, there was sudden onset of edema. Foard took to his bed. "I hope if no accident happens we shall soon have him on foot & make him forsake his now darling Bed to which he was never under the necessity of being so much attached before."

The letter goes on to request clothes for Foard and Pindell. Pindell states that he is in need of

his money which Williams lent to General Greene.

Apparently Foard died within several days of the amputation and was replaced as Lieutenant Colonel by John Eager Howard.

A number of physicians stopped practicing after the war. At least six became county judges. Fifteen physicians became members of the Order of Cincinnati. These were largely men with long and distinguished war records with regiments at the front. It is of interest that the two Maryland physicians who knew George Washington most intimately, James Craik (1730-1814), his personal physician, and James McHenry (1753-1816), one of his personal secretaries, did not become members of this Order. At least five physicians (Randall Hulse, Patrick Kennedy, Alexander Stenhouse, Upton Scott, and Henry Stevenson) left Maryland for England or joined the British Army. It is of great social interest that Scott and Stevenson returned after the war, and became founders of the Medical and Chirurgical Faculty, Scott being named first president! Seventeen veterans of the war were also founders of the Medical and Chirurgical Faculty.

Despite the grim list of administrative failures, of lack of medical supplies, of epidemics, and of starvation in the Medical Department of the Colonial Army, Hindle[63] concludes that America possessed more adequate medical skills than military or engineering skills needed to carry on the war. A few American physicians were veterans of the French and Indian War where they had seen British military medicine in action.

The Revolution had some beneficial effects on American medicine. A number of excellent practical textbooks were produced or reprinted for the use of Army doctors. Dr. John Jones' *Plain, Concise, Practical Remarks on the Treatment of Wounds and Fractures* (1775) set the tone, giving Jones' own experience in the Seven Years' War, as well as a review of the English literature.[64] Baron Van Swieten's *Diseases Incident to Armies with a Method of Cure*[65] was published in Philadelphia by R. Bell in 1776. Jones' book covers traumatic surgery, Van Swieten's hygienic measures, and common infectious diseases. Amusement and diversion are recommended to combat nostalgia, that protean disease of all armies of all ages masquerading under so many names. Benjamin Rush also contributed to the Army literature.[66]

Another positive accomplishment of the Revolutionary War was the performance and acceptance by physicians of medical examinations to establish standards of practice in the Army. Massachusetts established such a board in 1775 with a rigorous four-hour examination. In Maryland, Charles F. Wiesenthal examined applicants in surgery in 1778 and wrote recommendations to the Council even before this date.[61] James Murray was appointed Surgeon Examiner for the Medical Board in 1781, but this seems to have been a medical board for discharge of surgeons from the army. Such examinations of physicians by fellow physicians made such a method acceptable later for civilian licensing.

A third beneficial effect of the war was to force development of local medical resources, pharmacological,[67] chemical, and hardware. Many physicians were involved in this effort, and the result was development of self-reliance and independence of Europe.

A fourth beneficial effect was on the practice of medicine. The exposure to French military medicine, the experience with hospital practice, epidemics, and the necessity to use smallpox innoculation widely were all beneficial to the education of Colonial physicians.

## Aftermath of the Revolutionary War

In the two decades following the Revolutionary War, a number of important medical developments occurred in Baltimore. A medical school was started in 1789 and a medical society was started in 1788.

Both of these movements failed because of insufficient interest, demand, and support. All were to come into permanent existence in the early part of the nineteenth century with the founding of the Medical and Chirurgical Faculty in 1799.

A number of influences brought these movements into existence at the end of the eighteenth century.

The most important influence was the growth of Baltimore as a city. It was the last large city to develop on the East Coast, largely because the tobacco trade along the large estuary of the Chesapeake Bay allowed ocean-going vessels to go to each plantation, pick up tobacco, and trade it for products direct from London. There was no middleman.

The opening of roads to Western Maryland and the cultivation of wheat in the Frederick Valley required a middleman to store the grain while awaiting shipment. Mr. William Eddis, writing in 1769, describes the development of Baltimore and attributes it largely to John Stevenson.

"Within these few years, some scattered cottages were only to be found on this spot, occupied by obscure storekeepers merely for the supply of the adjacent plantations. But the peculiar

advantages it possesses, with respect to the trade of the frontier counties of Virginia, Pennsylvania, and Maryland, so strongly impressed the mind of Mr. John Stevenson, an Irish gentleman who had settled in the vicinity in a medical capacity, that he first conceived the important project of rendering this port the grand emporium of Maryland commerce. He accordingly applied himself with assiduity to the completion of his plan. The neighboring country being fertile, well settled, and abounding in grain; Mr. S. contracted for considerable quantities of wheat; he freighted vessels, and consigned them to a correspondent in his native country; the cargoes sold to great advantage, and returns were made equally beneficial. The commencement of a trade so lucrative to the first adventurers, soon became an object of universal attention. Persons of a commercial and enterprising spirit, emigrated from all quarters to this new and promising scene of industry. Wharfs were constructed; elegant and convenient habitations were rapidly erected; marshes were drained; spacious fields were occupied for the purposes of general utility; and within 40 years, from its first commencement, Baltimore became not only the most wealthy and populous town in the province, but inferior to few on this continent, either in size, number of inhabitants, or the advantages arising from a well-conducted and universal commercial connexion . . . Soon after the appointment of Mr. Eden to the government of Maryland (1768), Sir William Draper arrived in that province on a tour throughout the continent. He contemplated the origin of Baltimore and its rapid progress with astonishment; and when introduced, by the governor, to the worthy founder, he elegantly accosted him by the appellation of the American Romulus."[68]

Once a city had developed, sufficient physicians were gathered together to form a medical society; there were enough specialists for a medical school; and the resources in examiners and authority to set up licensing procedures.

A second development was improved education. A new merchant aristocracy desired the life of the English aristocracy. This class encouraged useful knowledge and supported the colonial colleges.[69]

All of these developments were not as important as the new intellectual climate of the late eighteenth century. For the great changes in Baltimore in the last two decades of the eighteenth century were the work of a group of young visionaries, trained and inspired in Europe, who returned to Baltimore after the war to implant with enthusiasm and hope the new European enlightenment. It is most interesting that none of these young men were veterans of the Revolutionary War.

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## Nursing Friends

The first annual Friends of Nursing Campaign will be launched in May, Anne Kibrick, EdD, president, National League for Nursing, New York, announced recently.

The campaign is designed to raise funds to help make good nursing available to all Americans, whenever it is needed, Dr. Kibrick explained. Contributions will go to the National League for Nursing and its constituent leagues to support and expand their programs for improving the quality of nursing education and nursing service. Both national and local league projects will benefit from the drive.

The main thrust of this initial campaign will be centered in five pilot states—Alabama, Kansas, Maryland, Massachusetts, and Ohio—whose leagues for nursing will conduct statewide fund-raising drives. Contributions will be welcome from Friends of Nursing everywhere.

The tax-deductible contributions fall into three categories: individual, $5; family, $10; special, $20. Checks should be made out to the National League for Nursing and mailed to NLN headquarters, 10 Columbus Circle, New York, NY 10019 or to the constituent league nearest you.

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# OPHTHALMIC THERAPY—THEN AND NOW

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*Presented before the American College of Apothecaries, October 3, 1971, Baltimore, Md.*

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Changes are occurring so rapidly in medical and pharmaceutic practice that we often lose sight of the pioneering efforts of the past. In fact changes are occurring so rapidly that many "new discoveries" that are reported in the professional literature turn out to be the rediscovery of old and long-forgotten or discarded facts.

We are told that 70% of the pharmacology taught in our medical and pharmacy schools today will be outmoded within ten years. How then can we approach a rational discussion of ophthalmic therapy? I have elected to do this by a comparison of the past and the present, with the hope that we will thus gain a new perspective for understanding the future.

Because of time limitations, I will review only local or topical medication for the eye.

## Purposes of Therapy

All therapy is directed at the relief of pain, the eradication of disease, and the restoration of function of the affected parts. Specifically, topical ocular therapy may be classified under four categories:

1) **agents for relief of pain,**
2) **anti-inflammatory agents,**
3) **anti-infectious agents, and**
4) **agents for special purposes.**

I shall attempt to review briefly some of the common drugs of the past and of the present in each of these categories. For this purpose I have searched through my collection of historic old medical books for remedies of the past. I am sure you will be amused by some of them.

## Agents for Relief of Pain

Many ocular conditions are associated with moderate to severe pain. Effective drugs for the topical relief of such pain have always been sought after, but have not always been available.

**Local anesthetics.** Cocaine alkaloid was first isolated from the leaves of *Erythroxylon coca* by Niemann in 1860. The plant had previously been introduced into Europe in the 16th century as a botanical curiosity after the Spanish conquered Peru and found that the aboriginal Indians had been chewing the leaves of the coca plant for many centuries to relieve fatigue. It was not until 1884 that Sigmund Freud requested and obtained a sample of the cocaine alkaloid from the Merck Company to try on a young physiologist who had become addicted to opium. Freud hoped to cure his dependency on opium by use of the cocaine, with the disastrous result that he produced a double addiction in the poor victim. However, in testing the cocaine, he discovered that it "had a somewhat bitter taste and exerted a numbing influence of the gustatory nerves, so that they became almost completely insensitive." This caused him to induce his friend and colleague, Carl Koller, a prominent surgeon, to test the anesthetic effects of the new drug. Koller tested cocaine in the eyes of frogs and guinea pigs, then his own eyes, and he succeeded in using it in the eyes of patients for superficial surgey. Koller was thus the father of local anesthesia, but it was Halstead here in Baltimore at The Johns Hopkins Hospital who in 1885 demonstrated for the first time that cocaine could be used to produce a nerve block.

How was pain in the eye treated before cocaine became available? In 1838 Benjamin Ellis, MD, Professor of Materia Medica and Pharmacy in the Philadelphia College of Pharmacy, published his famous *Medical Formulary,* a compendium described on the title page as "a collection of prescriptions, derived from the writings and practice of many of the most eminent physicians in America and Europe." In it we find a number of collyria for the relief of pain in the eye. It is interesting to note Dr. Ellis's definition of collyria: "These are prep-

arations applied to the eyes; they are sometimes dry, but generally liquid—consisting of infusions, decoctions or distilled water with the addition of various substances."

Here are three collyria recommended by Ellis for the local relief of pain:

1) **Opiate Collyrium**
Rx
Pulveris Opii, gr j
Camphorae, gr v
Mucilaginis Acaciae, oz j
Misce, et fiat collyrium

Can't you just visualize the epithelium of the cornea being denuded by the tenaceous acacia mucilage!

2) **Dry Collyrium of Opium**
Rx
Pulveris Opii, gr iv
Calomelanos
Sacchari purificati, aa gr xx
Tere bene
This was to be blown into the eye with a powder insufflator.

3) **Collyrium of Acetate of Ammonia with Opium**
Rx
Liquoris Ammoniae acetatis, oz ij
Aquae ferventis, oz vj
Extracti Opii mollis, gr x
Dissolve the extract of Opium in the hot water—strain, and add the liquor of acetate of ammonia.

Since it is now known with certainty that opium and its alkaloids exert absolutely no local anesthetic or anodyne effect, these preparations were worthless and in many instances harmful to the eye.

With the isolation of cocaine alkaloid, a new era opened in which modern ocular surgery was able to take root. However cocaine soon proved to be less than an ideal drug for use in the eye. It was not only toxic and habit-forming, but unstable in solution and irritating to the eye unless the solutions were prepared daily. In addition, cocaine solutions are a fine culture medium for bacteria and molds and soon become contaminated with both. Iantrogenic infections were common and total loss of an eye was not infrequent. Later it was found that cocaine solutions are harmful to corneal epithelium and produce serious corneal erosions if instilled into an eye with any degree of frequency.

Fortunately cocaine solutions are seldom used in the eye any longer. The newer synthetic local anesthetics have supplanted cocaine for the most part. If you are called upon to make up a solution of cocaine, the solution should be prepared with sterile distilled water under aseptic conditions, and should be dispensed in small sterilized dark bottles. A warning label should be attached to keep the solution in a cool place away from bright light. The addition of sufficient benzylkonium chloride to make a 0.01% solution, or of sufficient chlorbutanol to provide 0.15% of this agent, will help to stabilize the solution and preserve it against bacterial and fungal contamination. Greater concentrations of these additives should not be used or corneal damage may result.

In 1902 Willstatter succeeded in synthesizing cocaine, and this was followed quickly by the synthesis of a host of other analogues. In 1905 procaine hydrochloride (Novocain) was introduced. This drug still enjoys widespread usage for nerve block and spinal anesthesia, but it is totally ineffective when applied topically. Of the very large number of local anesthetic agents which have been introduced over the years, only two enjoy universal usage in ophthalmology at the present time. These are proparacaine hydrochloride (Ophthaine, Ophthetic), and tetracaine hydrochloride (Pontocaine). They are effective as local anesthetics for the eye and they exert the least harmful adverse effects upon the corneal epithelium. Tetracaine solutions have the advantage of chemical stability over long periods of time. They have an indefinite shelf life and do not require refrigeration after the package is opened. Proparacaine solutions have a short shelf life and must be refrigerated after the package is opened in order to retain their effectiveness for even a week or two. If the solution takes on a straw-colored appearance it should be discarded.

### Anti-Inflammatory Agents

The eye is subject to numerous inflammatory diseases which are not the result of infection. Allergies constitute a very large percentage of such cases. The use of astringent collyria for relief of local inflammation goes back into antiquity. The ancients knew the astringent properties of alum and of copper. They often placed a flax seed in the eye to reduce inflammation. Ellis provides several formulas for such collyria in the 19th century:

4) **Dry Collyrium of Sugar**
Rx
Sacchari albi,
Oxidi Zinci, aa partes equales
Tere in pulverum. To be insufflated into the eye.
(Attributed to M. Recamier, 17th century)

5) **Alum Curd**

Rx

Pulveris Aluminis, 3 ss
Albuminem Ovi, j
Agitate well until coagulum formed. To be applied on a linen rag to inflamed eyes for 3 to 4 hours.

6) **Collyrium of Acetate of Zinc**

Rx

Sulphatis Zinci,
Super-acetatis plumbi, aa gr vj
Aquae rosarum, oz iv
Fiat solutio

A double decomposition takes place. Acetate of zinc is held in solution, while sulfate of lead falls to the bottom. It should be filtered out without shaking.

7) **Emollient Collyrium**

Rx

Radicis Althaeae officinalis, 3 ij
Aquae distillatae, lb j
Infuse for 3 hours near the fire, and strain.

The use of vegetable oils as an emollient protective coating for the eye was recommended in the 18th century. Early in the 20th century the local use of castor oil was introduced to protect the eyes against the harmful effects of the volatile anesthetics, ether and chloroform, which were commonly administered through a cloth mask or a sponge held over the mouth and nose. In modern ophthalmologic practice methyl cellulose solutions have almost completely replaced such vegetable oils, which could be so very irritating if old and rancid. Methyl cellulose is a methyl ether of cellulose which swells when placed in water to produce a clear, opalescent viscous colloidal suspension. These are offered in several concentrations for specific purposes. An 0.5% solution of methyl cellulose in 0.9% sodium chloride solution is an excellent artificial tear and is very useful in relieving the "dry eyes" of older patients and wherever a protective coating for the cornea is desired. The more viscous 1% solution is used as a contactant-lubricant for the application of the gonioprism to the cornea for inspection of the angle of the eye.

True anti-inflammatory agents did not make their appearance on the therapeutic scene until the 1940s, when the antihistamines were introduced. There are many legend compounds on the market containing antihistamines for local application to the eye for the relief of inflammation, especially in allergic states. The local use of antihistaminics is of no proven value in such conditions, and may cause alteration of the presenting signs so as to mask more serious pathology later. There is no place in rational therapeutics for the use of locally applied antihistaminics to the eye.

Vasoconstrictor solutions have long been used to relieve irritation in the eye, and enjoy considerable popularity at present in both legend and OTC preparations. Occasionally patients will exhibit adverse reactions to these preparations in the form of more severe congestion as the drug wears off (the so-called "rebound effect") and rarely by dilatation of the pupils which lasts for several days and is quite annoying. Usually the side effects clear promptly upon discontinuance of the drugs. Sometimes mild astringents are included in the formula as well.

The introduction of steroids in 1946 (ACTH) opened wide new vistas for therapy of both superficial and intra-ocular inflammations. The use of such preparations, especially topically, is widespread in ophthalmology and has restored many eyes to useful vision which would have otherwise been doomed to eternal darkness. However the use of the steroids in the eye is not without some danger, so that no steroid eye drops should be prescribed except after careful and accurate diagnosis. Patients placed on such therapy require frequent observation by the ophthalmologist. What are some of the hazards?

In the first place, what may appear to be a trivial abrasion of the cornea may in truth be an early lesion of herpes simplex, the virus disease usually associated with fever blisters and canker sores of the mouth and lips. Only a qualified ophthalmologist can differentiate the early lesions. The use of steroid eye drops or ointments in such herpetic keratitic infections may be disastrous and cause the patient to suffer serious loss of vision.

A second hazard: the continued use of steroid drops in the eye over a prolonged period of time renders the eye susceptible to invasion by bacteria and fungi. The natural resistance of the ocular tissues is obtunded by the steroid, and the infection which takes hold may prove very stubborn and difficult to eradicate. Loss of vision may be the ultimate result.

Another hazard: the long-continued local application of steroids to the eye may cause a marked elevation in the intra-ocular pressure and predispose to glaucoma. Whenever steroid ophthalmics must be continued over a long period of time, it is imperative that intra-ocular tension readings be done regularly by the ophthalmologist.

Unfortunately the vast majority of steroid eye preparations are prescribed by physicians other than ophthalmologists, and no such careful control is carried out. The pharmacist can render a genuine service by refusing to refill steroid eye preparations beyond a three-month period without further authorization from the physician. It is true that many cases of intra-ocular inflammation will go blind if the steroids are not continued without interruption for months, or even years, but the burden of responsibility in such cases belongs to the physician, not to the pharmacist.

### Anti-Infective Agents

Man has sought to conquer infection since the beginning of time. In the Old Testament the Book of Proverbs refers to the use of vinegar on wounds (25:20). In the New Testament, Luke describes how wounds were treated in the manner of the Good Samaritan, who "bound up his wounds, pouring in oil and wine." (10:34). Chemicals such as copper sulphate and silver nitrate were described as being cauterizing agents for wounds in the early medical writings of the Romans and Greeks. Similar collyria were in vogue in the late 18th and early 19th centuries, for example:

**8) Collyrium of Vinegar**
Rx
Aceti distillati, oz j
Spiritus Vini Diluti, oz ss
Aquae rosarum, oz viij

**9) Collyrium of Sulphate of Copper**
Rx
Sulphatis Cupri, gr vj
Camphorae, 3 j
Aquae ferventis, oz viij
Rub the camphor with the water—then strain, and add the sulphate of copper. Ellis's comment:
"Recommended by Ware in the treatment of purulent ophthalmia."

**10) Collyrium of Corrosive Sublimate**
Rx
Hydrargyri Muriatis, gr ij
Aquae distillatae, oz viij
Fiat solution

This was recommended for ophthalmia due to gonorrhea and scrofula.

In 1907 Paul Ehrlich developed arsphenamine (606, Salvarsan)—the first specific drug. Thus was born the new era of chemotherapy, and the search for a "*Therapia Sterilizans Magna*" has never ended. A long array of heavy metal antiseptics followed, all of which found advocacy in ophthalmic therapy. These include the once popular Argyrol, Mercurochrome, Methiolate, etc. None are prescribed any longer as antibacterial agents for ocular infections but some are still used as preservatives in ophthalmic preparations.

Among the by-products of World War I was the synthesis of para-amino-benzene-sulfonamide, or sulfanilamide, by Gelmo in 1906 while preparing dyes for the war machine which Germany was then building. Since it did not prove of value as an explosive he discarded it. In 1932 Domagk began a review of the compounds discarded by Gelmo. He developed an active compound containing essentially the same chemical structure which proved effective in protecting mice against septicemia caused by hemolytic streptococci. He named the drug Prontosil. Additional sulfonamide compounds were synthesized in rapid succession. Some have withstood the test of time and are still prescribed; others have been discarded because of toxicity or lack of effectiveness.

The sulfonamides are useful in the eye as anti-infective agents provided there is no frank pus present. Para-amono-benzoic acid (PABA) is a structural analog of sulfanilamide and is an essential metabolite for bacterial reproduction. The presence of PABA will inhibit the action of sulfonamides. PABA is present in pus, and hence sulfonamides are ineffective where pus is present. Sulfacetamide has proven to be the best agent of this group for the eye. It is usually prescribed in 10-15% aqueous solutions containing 0.5% methyl cellulose. It is well tolerated in this formulation. There is also marketed a 30% solution in water without methyl cellulose (Sulamyd) which is caustic and designed only for use in severe indolent ulcers of the cornea. This should never be dispensed in lieu of the milder and weaker solution containing methyl cellulose. Sulfonamide ophthalmic ointments are also available.

Penicillin was introduced in 1928 after Alexander Fleming noted that colonies of staphylococci which had become contaminated with the *Penicillium* mold were undergoing lysis. It is not much used at present because newer agents have been more effective and because of the danger of sensitizing the patient to penicillin. Antibiotics which find considerable local usage in the eye at the present time include gramicidin, neomycin, polymyxin B, chloramphenicol, tetracycline, oxytetracycline, and bacitracin. In most antibiotic eye preparations, several of the above are

to be found so as to broaden the spectrum of effectiveness. Recently gentamicin was isolated, and this has proved to be the antibiotic with the broadest spectrum of activity of any known. It is effective against both gram-positive and gram-negative cocci and rods. It is especially effective against the dreaded *Pseudomonas aeruginosa.* It is marketed under the trade-name, Garamycin Ophthalmic Solution and Ointment.

Viral infections of the eye are not uncommon. The most common virus to attack the eye is the common herpes simplex virus, which has a marked predilection for the cornea. One anti-metabolite agent has been found to be almost specific in controlling this virus. Idoxuridine (IDU) is closely related to thymidine, an amino acid, which is essential as a metabolic precursor for the reproduction of the virus. Idoxuridine (IDU) competes with the thymidine to sharply reduce the reproductive capacity of the virus and ultimately causes its elimination from the tissues. This agent is available in solution and ointment form (Stoxil, Herplex and Dendrid). These preparations have a short shelf life and must be fresh to be effective. The patient must avoid boric acid coming in contact with the eye while the IDU therapy is in effect; otherwise, the combination will prove extremely irritating to the eye.

Fungal infections of the eye are not common and are usually seen as a complication to long-standing usage of either anti-infective agents or steroid preparations, or both. The suppression of the normal flora of the eye enables the fungi to emerge and invade the tissues. Several antifungal agents are used topically in the eye. Sodium proprionate 2.5% aqueous solutions are often effective. In unresponsive cases, 0.1% solutions of amphotericin B (Fungizone) are often used, or freshly made suspensions of mycostatin (Nystatin) 100,000 units per cc. This last preparation is unstable unless refrigerated. Prolonged treatment is sometimes necessary to prevent recurrences.

## Agents for Special Purposes

These are among the most important drugs used in ophthalmology. The eye represents a unique pharmacologic laboratory for the study of many special drugs. Its clear corneal window permits observation of the pupil; and easy measurement of the accommodation in response to drugs make this an ideal model in which to study drugs which affect the autonomic nervous system.

### Mydriatics & Cycloplegics

Belladonna has been known since ancient times. The drug acquired its name, Bella Donna ("beautiful woman") because the women of Rome and Greece used to apply it to their eyes to dilate their pupils and enhance the beauty of their eyes. In 1881 atropine was isolated from belladonna and its chemical structure was identified. A typical early 19th century prescription follows:

**11) Solution of Extract of Belladonna**

Rx

Extracti Belladonna, gr xx
Aquae distillate, oz iij
Fiat solutio.

Signa—to be applied to the eye in cases of cataract, for the purpose of dilating the pupil and exposing the lens.

The problem with belladonna and its alkaloids (atropine, hyoscymine, and hyoscine) is that they produce a cycloplegia of long duration —five to eight days. The synthesis of homatropine was a great boon to ophthalmologists, therefore. Since its action lasts 24 to 36 hours, it can be overcome by the use of strong miotics, if necessary. Currently, newer rapid-onset and short-duration preparations are used: Mydriacyl 0.5% and 1%, and Cyclogyl 1% and 2%. These are extremely effective for funduscopic study and for refraction.

Atropine is still the drug of choice in young children and poses a serious threat by its great toxicity. It must be borne in mind that 0.2 ml. of 2% atropine sulfate solution contains 4 mg of atropine sulfate! This is a toxic dose if absorbed and may prove fatal in young children if repeated several times a day. The pharmacist should always remind the parents to apply pressure over the lacrimal duct whenever atropine is instilled into a child's eye.

### Miotics and Cyclotonics

This large group of drugs is usually spoken of as the *cholinergic drugs* as they simulate the action of acetylcholine. Eserine is perhaps the oldest known drug in this group but is seldom used in the eye now because its solutions are unstable and its effects are therefore unpredictable. Pilocarpine is the most widely used of the group at the present time. It acts directly on the smooth muscles of the ciliary body rather than by inactivation of cholinesterase. Its action is of rapid onset and of moderate duration—about four hours. The newer synthetic, ecothiophate (Phospholine Iodide), is more toxic than pilocarpine but even in very weak solutions it produces a long-lasting miosis—12 to 24 hours. Hence it can often be used on a once or twice a day dosage schedule, rather than every four

hours as with pilocarpine. This is particularly valuable in glaucoma, where continuous and long-lasting effects are most desirable. A newer usage for these cholinergic drugs is as an adjunct in the treatment of accommodative esotropia ("crossed eyes") in children. However it should be borne in mind that these drugs are highly toxic and the lacrimal ducts should be blocked with the finger after each application to prevent undue absorption of the drug.

Interestingly, the toxic effects of these agents can be put to good usage occasionally. One such instance is for the treatment of pediculosis of the eyelashes. Whereas DDT and other pesticides are too irritating to apply to the eyes, eserine ophthalmic ointment is most effective if applied several times a day to the eyelashes and eyelid margins for several days. Its greatest complication is a miotic pupil and a sharpened focus.

## Modern Ophthalmic Therapy

There are several routes by which drugs may be employed for the treatment of ocular disease:

1) **topical,**
2) **subconjunctival,**
3) **retrobulbar, and**
4) **systemic.**

Although all of these routes are used in modern ophthalmic therapy, the topical preparations still constitute the most important group. Fortunately a very large number of useful drugs exert both a surface action and are absorbed into the eye. Notable exceptions are antibiotics, which are not absorbed well at all. Absorption depends upon the partition coefficient and the bisolubility of the active ingredient (s) .

In an effort to increase effectiveness of drugs in the eye, various additives have been employed to lower the surface tension and retain the drug in contact with the cornea for increased periods of time. The usual aqueous solution remains in the eye for one half to one minute only. Ointments, on the other hand, remain in the eye for seven to ten minutes. By adding detergents (benzylkonium chloride) or surfactants such as 0.5% methyl cellulose and 1.4% polyvinyl alcohol, one can increase the contact time to seven to eight minutes, A newer modality for applying drugs to the eye is the use of soft contact lenses. These plastic lenses are cellular and, when soaked in ophthalmic solutions, provide a continuous flow of medication for many hours. This will prove most helpful in glaucoma as the technique becomes perfected.

For greatest effectiveness and maximum freedom from irritation, solutions of eye preparations should meet certain pharmacologic and pharmaceutic criteria:

1) The preparation should have *an aqueous base* unless the peculiar nature of the active ingredients requires a different solvent.
2) The solution should be *isotonic with the tears of the eye.* Although the eye tolerates well solutions of sodium chloride of 0.6% to 1.5% concentration, solutions should be prepared to have the isotonicity of 0.9% sodium chloride solution whenever possible.
3) The solution should have a *pH of approximately 7.3* as this is the normal pH of the tears. However the eye tolerates well solutions with pH values of 6.6 to 9.0.
4) It is preferable for the solution to *contain buffer salts* to assist in stabilizing the pH. This is not a critical requirement however as the tears are highly buffered.
5) The solution should be *sterile and self-sterilizing.* Carefully selected preservatives may be necessary as additives to the solution.
6) The solution should *contain an additive* such as methyl cellulose or polyvinyl alcohol to increase the contact time of the active ingredients with the ocular tissues.
7) The solution should be dispensed in a container which provides some mechanism for delivering uniform and predictable dosage to the eye.

Thus the role of the pharmacist in ocular therapy has changed from that of a compounder of preparations of dubious merit, and of potentially harmful side effects because of lack of sterility, to one of being an expert in seeing that properly prepared solutions and ointments are dispensed with proper instructions for safe usage.

In addition, the pharmacist has assumed a very valuable role if he keeps a drug profile on each of his clients and can advise the ophthalmologist when a glaucoma patient is also taking anticholinergic preparations for some other reason, for example. This may spell the difference between saving the patient's sight and losing it completely because of therapeutic incompatibility. Though you are less of a technician now, you are infinitely more important in the management of disease. I trust this presentation has served in some small measure to better prepare you for your newer role.

# ECOLOGY OF COASTAL MARSHES

**FRANKLIN C. DAIBER**
**Professor of Biological Sciences**
**Director, Marine Laboratories**
**University of Delaware**
**Newark, Delaware**

*From an environmental pollution paper presented at the semiannual meeting of the Medical and Chirurgical Faculty of Maryland, September 11, 1970, Hershey, Penna. This was a William Royal Stokes Memorial Fund Lecture.*

*Information and reprint requests to Mr. Daiber.*

Tidal marshes mean different things to different people. They give rise to mosquitoes and biting flies that make life miserable. They are filled with a sticky odorous mud that clings to boots and clothing. Most people stay away from coastal marshlands, yet hunters and trappers know that these regions can provide sport, food, or considerable financial yield. Fishermen find they can take turtles, shellfish, and fish from the tidal streams that wander through these marshlands.

Tidal marshes may be used in different ways. They can be receptacles for the discards of man's activities — tin cans, old cars, refrigerators, and other rubbish that plague the landscape. When leveled off and packed down this refuse becomes an industrial plant site, or perhaps a new housing development. Our expanding population, with all its associated needs for more land and new sources of food, has created an interest in tidal marshes. The purpose of man-made changes in coastal lands is obvious. But what of the natural role of marshes? Here is a matter of conflicting interests.

Ever since man has been a hunter he has known that he can get food from these tidal marshes. Now, hunting and fishing for recreation replace the need for food. Conservation departments must maintain maximum levels of wildlife resources in ever diminishing marshland for increasing numbers of sportsmen. More people with more money and time available are looking to the seashore as a place to spend their vacations. Naturally they are annoyed by anything that will cause undue discomfort during this time.

Their ire increases in direct proportion to the number of mosquito bites they receive. State and federal agencies have tried to control mosquitos and biting flies. Ditches are dug to drain the marshes to reduce the mosquito breeding sites. Potent insecticides are sprayed over wetlands and adjoining areas to kill mosquitoes that survive the results of ditching. The impoundment of water over marshland areas has been tested as a means to control the salt marsh mosquito, and also to enhance these areas for waterfowl and other wildlife. There has been interest in the development of these impoundments for aquaculture.

There are now fewer acres of tidal marshes than in former years, yet there are more people who want to use these marshes for different reasons. How many acres of marshland can be utilized for other than their wild role; how many can we afford to lose before the natural productivity of our coastal waters is impaired? How can we use these marshes for the maximum benefit for most people with a minimum of disruption? These are some of the questions that are facing our society today, conservation departments, industries, private citizens, scientists. In recent years investigators have been seeking answers to these questions in the marshes of New England, Long Island, Delaware, and Georgia, to name only a few places.

Let us define a tidal marsh as an area of land bordering on the sea, more or less covered by vegetation, and subject to periodic inundation by the tide. We recognize three subdivisions to the marshes of the Atlantic coast. First, those of the Bay of Fundy with deep layers of compact soil and extensive tides, formed in front of soft coastal cliffs with a high red silt content. The second subdivision is the salt marsh of New England, extending into northern New Jersey and comprised of marine peat with very little silt resulting from the igneous rock of New England. The third type has a reduced tidal range and begins in south Jersey, extending into Florida. The marsh soils are shallow and comprised of soft silt derived from the sedimentary rocks characteristic of the region.

Marshes are formed in association with rising or falling sea level, or land submergence on intertidal sand spits, bars, or coastal islands

where the current flow is reduced. First, we have the submergent vegetation—the attached algae and rooted plants associated with sediment accumulation. There is a subsequent vegetation change from the submergent to the emergent kind, finally to vegetation that is completely out of the water except in the highest tides.

From an ecological point of view, tide marshes can be classed as an ecotone, an ecological zone between two major but unlike ecological habitats, uplands on the one hand, and the sea on the other. There are definite vegetation zones affected by the extent of tidal inundation and the salt content of the sea water, the extent of ground water levels and the degree of waterlogging of the soils. We can subdivide this ecotone into low and high marshes. The low marshes are characteristically submerged by the tides, usually twice a day, whereas the high marshes have fewer submergences.

The cord grasses are the most characteristic kind of vegetation that one sees on the surface of the marsh, but in addition we have filamentous algae and diatoms growing on the surface muds. The characteristic animals include fiddler crabs, marsh crabs, the ribbed mussel, and certain species of snails. There are fish unique to these marshes along with the diamond-back turtle. During the early summer, the willets are a very obvious form of bird life. The muskrat is a characteristic mammal.

The University of Delaware has been involved in the study of tide marshes for many years. The Department of Entomology and Applied Ecology has directed its efforts towards understanding the means for insect control and how such control can affect other organisms living in these tidal marshes. Marine Laboratories has directed its attention primarily to the questions: What is the role of a tidal marsh? What does it contribute to the biological economy of estuaries and the coastal environment? Another way of asking the same question is: What is the effect on estuarine and coastal productivity when tidal marshes are modified?

We have found that tidal creeks are very active places, particularly during the summer. These creeks are utilized by a great variety of fish during some period in their life cycles. The eggs and larvae are brought in on the flooding tide, returning on the ebb. At the same time other species in later stages of the life cycle use these creeks as resting or feeding sanctuaries. This fish activity is most prevalent during the summer months when insect control is most obvious.

We know that large volumes of water move in and out of these creeks. For example, the Broadkill River has a net down-stream discharge of six million cubic feet of fresh water during each tidal cycle. We know this water carries large quantities of organic detritus, inorganic silt, and plant nutrients, as well as plants and animals themselves.

There are considerable quantities of phosphorous—one of the important plant nutrients —transported out of these tidal creeks during each tidal cycle, particularly during the summer months. These phosphates come from the erosion of the uplands, from plant and animal activities on the marsh surface, dissolved from the marsh sediments, from the fertilizers that are applied to the adjoining farm lands, from the detergents that are used in every household, and from some of the insecticides that are utilized to control mosquitoes and biting flies.

Interestingly enough, nitrogen, which is another important element in the life cycle of all living organisms, is much more abundant during the winter months than during the summer. It is unclear as to whether we have more coming into the marsh from the bay waters, or whether there is more going out. The nitrogen loads that are released from sewage treatment plants obscure this picture.

We have considerable evidence that the natural marshes seem to release greater quantities of phosphorus and nitrogen into the bay, whereas ditching or impoundments have a degrading effect on the quantity released into the bay waters.

We know that various species of bacteria play very important roles in the phosphorus and nitrogen cycles. Two groups of sulfur bacteria have a very profound influence on the quantities of phosphate ion that will be available for use by other organisms. Bacteria are involved in the nitrogen cycle, affecting the quantities of nitrate available for plant use. Bacteria are active in the production of vitamin B-12, important in the life cycles of plants and animals; greater quantities of vitamin B-12 leave the marshes than come in.

We know these tide marshes are very productive. The cord grass which is so evident on the marsh surface produces four thousand pounds dry weight during a growing season without any cultivation by man. These kinds of figures substantiate the view held by Dr. Odum and others that these tidal marshes are among the most productive areas of the world, in contrast to

the open ocean or some of the agricultural lands. We know that some of the energy produced in these marshes is recycled and used over again by the plants and animals that live there, but we do not know the proportion or how often it is recycled. A large quantity is carried into the bay and the adjoining coastal waters on the ebbing tides.

We like to think of the tide marshes as a bank where energy is stored and then released at certain times of the year. The marsh plants seem to be most valuable after they have died. They decay on the marsh surface forming organic detritus or are swept out to sea on the ebbing tide releasing nutrients for subsequent plant generations.

What is the significance of all of this? We ask the questions: What is the relationship between the ratios of the phosphorus and nitrogen that we see during different times of the year? When is phosphorus a limiting factor in terms of plant production, or does nitrogen become a limiting factor during some time of the year? It is very evident from a chemical and biological point of view that these marshes are in very delicate balance. There is a very fine relationship between pH levels, oxygen availability, iron solubility, bacterial activity, and phosphate concentrations. There are daily tidal changes, changes related to the moon's cycle, and seasonal changes.

How does man's activity influence this delicate balance? Just how much of the energy that is stored in these plants is released and made available to the organisms that are living in these marshes and how much of it becomes available to those organisms living in the bay and the open ocean? Such energy releases can determine how much fish and shellfish will be available for harvest by fishermen.

And lastly, what is the effect of man's manipulations? We know that impoundments and ditching have an influence on the phosphorus and nitrogen cycles. What are the direct and possible indirect effects of pesticides on the life cycles of these organisms? How many animals are killed outright during some stage in their life by the application of certain pesticides? What effect do repeated low concentrations have on the reproductive cycles of these organisms? How do the detergents that are not broken down in the sewage treatment plants, and the fertilizers entering from upland drainage of farm lands affect productivity and the well-being of marine and bay organisms. I am impressed by how fragile these tide marshes are. We have learned much, but we still seek more complete answers to the questions: What role do these marashes play, and what effect does man's manipulations have? How many acres of these marshes can we afford to give up for other purposes without affecting the rich coastal environment?

These questions cannot be left entirely to the scientists, but to all walks of life and ages. It is critical that sound decisions be made and that you have an understanding of the complex interactions that characterize our tidal marshes.

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**MEDICAL AND CHIRURGICAL FACULTY**

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WHILE PARTICIPATING IN A CONTINUING
MEDICAL EDUCATION PROGRAM

# ANTICIPATORY GUIDANCE FOR ABORTION

**LOUIS W. TINNIN, MD**
**Senior Psychiatric Consultant**
**Student Health Service**
**University of Maryland**
**College Park, Maryland**

**MARGARET W. BRIDWELL, MD, FACOG**
**Staff Gynecologist**
**Student Health Service**
**University of Maryland**
**College Park, Maryland**

*Information and reprint requests to Dr. Tinnin, 608 Washington Blvd, Laurel, Md 20810.*

The Student Health Service of the University of Maryland at College Park has made abortion referrals and follow-ups since July of 1970 when a full-time gynecologist joined the staff. The experience has been extensive with a referral rate of about ten per week. The gynecologist is assisted by two volunteers daily from the Montgomery Planned Parenthood Association and a counseling psychologist two days a week. Psychiatric consultation is available.

The pregnant patient requesting abortion is interviewed at some length to determine what planning she has done and to offer guidance. She is helped to consider the alternatives to abortion and to decide about involvement of boy friend, family, or others. She is told about clinics available in the area, the cost, type of procedure, and generally what to expect. A return appointment is made for about ten days for a follow-up physical examination, birth control advice, and a talk.

The reports of these girls have shown that there are two fundamental psychological tasks to be faced when one has an abortion. First the woman must accept the full reality of her pregnancy and the full personal impact that it carries. Then she must prepare for, carry through, and grieve as necessary the full relinquishing of the pregnancy. The failure to complete these tasks accounts for the problems that sometimes emerge afterwards. The physician should be alerted to difficulties when the patient regards her pregnancy as a simple bother which must be removed without further ado. She may be emotionally denying the fact of pregnancy, dealing with it as she would a toothache, and evading the troublesome issues involved.

The problem of *unresolved grief* after an abortion may be a subtle one, insidious or delayed, or it may present as depression. This is more likely if there has been a serious loss earlier—such as the death of a parent or sibling. The previous grief may be reactivated as depressive illness. More commonly the effect is a vague and diffuse disturbance, draining energy and vitality, disturbing sleep, and sometimes experienced as unyielding loneliness.

Failure of the basic tasks sometimes results in a disturbed *protest reaction* with unjustified anger at others, projection of blame, and bitter feelings of being cheated. A transient feeling of protest should be regarded as normal and expected, but the patient can become trapped in this phase of reaction.

We have found that these reactions can be prevented by *anticipatory guidance* to help the patient deal with the basic psychological tasks and to prepare for the experience of abortion. We routinely include the following basics:

1) We encourage her to verbalize her experience of pregnancy. In addition to how and why she became pregnant, she talks about her physical sensations, her feelings about the state of pregnancy, and her fantasies about the unborn child.

2) We ask her to fully consider and verbalize as much as possible all of her feelings, pro and con, even though she has made her decision about abortion.

3) We describe the expected setting, the procedure, the pain and the recovery period. Sometimes we demonstrate and explain the instruments to be used.

4) We prepare her for the mixed feelings to be expected; feelings of relief, loss, protest, detachment, and grief. She is advised to permit these feelings and let them take their natural course.

When the patient has decided to involve her boy friend, he should be included in the anticipatory guidance, and equal concern should be given to his completion of the psychological tasks.

We try to give the patients kind, supportive, non-judgmental care during this crisis. At the same time we expect them to deal with the psychological tasks themselves with full awareness. They do indeed have to accept the pregnancy, give it up, and grieve. We believe that if this can be done, the great majority of patients in this age group will not be left with problems in future years.

# Action by the Commission on Medical Discipline

Editor's Note: On instructions of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order," will be published in the MARYLAND STATE MEDICAL JOURNAL on a regular basis.

As cases become final after action by the Commission on Medical Discipline, they will be published. The following cases are a partial list of those that have been handled since the Commission's inception. Others will be published as received from the Commission.

### GEORGE H. BECK, MD

Upon the complaint of the Medical and Chirurgical Faculty of the State of Maryland, the Commission directed the Respondent, George H. Beck, MD, a physician licensed by the Board of Medical Examiners of the State of Maryland, to answer charges of violation of Article 43, Section 145, of addiction to narcotics. After due notice to the Respondent, a hearing was held on Thursday, May 14, 1970, before the Commission on Medical Discipline. Respondent was present and was represented by George Zavadil, Esq., Attorney.

#### FINDINGS OF FACT

The Commission heard testimony from Sergeant Raymond Donovan of the Baltimore County Police, Mr. Joseph Seivold, Probation Officer of the Baltimore County Circuit Court, and Dr. Beck. The Commission finds from this testimony and the exhibits offered at the hearing, as follows:

1) Dr. George H. Beck was, prior to his arrest in December of 1967, addicted to the narcotic drug "Demerol." Subsequent to his arrest and trial in the Baltimore County Circuit Court, Dr. Beck has ceased to take the narcotic drug "Demerol," under the supervision of the probation officer, Mr. Seivold.

2) Dr. Beck is in need of continuing medical consultation and supervision in order to effect a permanent and meaningful cure for his addiction.

#### CONCLUSIONS OF LAW

On the basis of the foregoing Findings of Fact the Commission concludes that the Respondent is guilty of violation of Article 43, Section 145 of addiction to narcotics.

#### ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 14th day of May, 1970, by the Commission on Medical Discipline, ORDERED that the license to practice medicine of George M. Beck, MD is revoked effective June 25, 1970. This revocation is to be stayed and indefinite probation is to be granted Dr. Beck upon satisfactory compliance with the following conditions:

1) Voluntary surrender of Federal Narcotics Permit or License.

2) Participation in a planned program of therapy acceptable to the Commission with the receipt of quarterly reports from the attending physician.

3) The Respondent shall report as ordered at quarterly intervals before the Commission.

4) The Respondent is ordered to appear before the Commission on Medical Discipline on June 25, 1970, at 3 o'clock p.m. to present evidence that the above conditions of stay and probation have been met.

/s/ JOHN M. DENNIS, MD, Chairman

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### CHRISTOPHER MENDELIS, MD

Upon the complaint of the Medical and Chirurgical Faculty of the State of Maryland, the Commission directed the Respondent, Christopher Mendelis, MD, a physician licensed by the Board of Medical Examiners of the State of Maryland, to answer charges of violation of Article 43, Section 145, of unprofessional conduct. After due notice to the Respondent, a hearing was held on Thursday, June 25, 1970, before the Commission on Medical Discipline. Respondent was present and was represented by Oscar W. Zenitz, Esq., and Walter I. Seif, Jr., Esq. Attorneys.

#### FINDINGS OF FACT

The Commission heard testimony from Mrs. Edith R. Gick and Dr. Christopher Mendelis. The Commission finds from this testimony as follows:

On Wednesday, February 26, 1970, Mrs. Gick visited Dr. Mendelis in order to have some papers filled out to get Blue Cross insurance. Her weight, height, and blood pressure were taken in order to complete the form. She was asked by Dr. Mendelis if she had begun to change life, and she indicated to him that she had not and that the only thing that had happened to her was that her periods were every 21 days. The doctor suggested birth control pills to properly regulate her periods. This required examination of the breasts to make sure there were no lumps. In the examination of Mrs. Gick's breasts, Dr. Mendelis, rather than giving them a proper medical examination, caressed and kissed them. He denies having done this but the Commission finds the credible testimony was that of Mrs. Gick who described in detail the actions of Dr. Mendelis.

#### CONCLUSIONS OF LAW

On the basis of the foregoing Findings of Fact, the Commission concludes that Respondent is guilty of violation of Article 43, Section 145 of unprofessional or dishonorable conduct in that he engaged in immoral conduct in his practice as a physician.

#### ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of June, 1970, by the Commission on Medical Discipline, ORDERED that Dr. Christopher Mendelis be placed on probation for the practice of medicine for the period of two years and that he report to the Commission at three month intervals.

Dr. Mendelis will be notified thirty days prior to each regular meeting of the Commission to which he is to report.

/s/ JOHN M. DENNIS, MD, Chairman

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### SIMON H. CARTER, MD

Upon the complaint of the Medical and Chirurgical Faculty of the State of Maryland, the Commission directed the respondent, SIMON H. CARTER, MD, a physician licensed by the Board of Medical Examiners of the State of Maryland, to answer charges of violation of Article 43, Section 130 (h), of unprofessional conduct. After due notice to the respondent, a hearing was held on Friday, November 27, 1970, before the Commission on Medical Discipline. Respondent was present and was represented by Charles P. Howard, Jr., Esq., attorney.

#### FINDINGS OF FACT

There was introduced in evidence before the Commission a report of the Mediation Committee of the Medical and Chirurgical Faculty of Maryland, under date of October 23, 1970 (Commission's Exhibit #1) wherein it was stated that Dr. Carter, among others, had appeared before that Com-

mittee in September of 1969 and readily admitted that he had signed incorrect medicaid prescription blanks. The Commission heard testimony from Dr. Carter and Dr. Carter again admitted, to the Commission, that he had signed incorrect medicaid prescriptions. Dr. Carter further admitted that he believed that he had been negligent in this respect.

CONCLUSIONS OF LAW

On the basis of the aforegoing findings of fact the Commission concluded that the respondent was guilty of violation of Article 43, Section 130 (h) of unprofessional conduct.

ORDER

Upon the foregoing findings of fact and conclusions of law, it is this 27th day of January, 1971, by the Commission on Medical Discipline of Maryland,

ORDERED, that Dr. Simon H. Carter be and he is hereby reprimanded and, be it further,

ORDERED, that a copy of the foregoing findings of fact, conclusions of law and this order be filed with the Board of Medical Examiners of the State of Maryland and that a copy hereof be mailed to the respondent and Charles P. Howard, Jr., Esq., his attorney of record, forthwith.

/s/ JOHN M. DENNIS, MD, Chairman

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SHIRLEY R. CLINTON, MD
EDWARD E. HOLT, MD
EVAN A. GILKES, MD
HOLLIS SEUNARINE, MD

Identical charges to those in the matter of Dr. Carter were also heard by the Commission on November 27, 1970 against Drs. Clinton, Holt, Gilkes, and Seunarine. Identical Findings, Conclusions, and Orders were also issued the 27th day of January, 1971.

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JOHN FRANCIS COOLAHAN, MD

Upon the complaint of the Commission on Medical Discipline of Maryland the Commission directed the Respondent, John Francis Coolahan, MD, a person licensed to practice medicine and surgery in Maryland by the Maryland State Board of Medical Examiners, to answer charges of having been convicted of a crime involving moral turpitude and of having promoted, as a physician, the sale of drugs, devices, appliances or goods provided for patient in such a manner as to exploit the patient for financial gain. After due notice to the Respondent, a hearing was held on Thursday, April 15, 1971 before the Commission on Medical Discipline of Maryland. The Respondent appeared and was represented by John W. Moyer, Esq., his counsel.

FINDINGS OF FACT

The Commission found that the Respondent had been convicted of a crime involving moral turpitude (Commission's Exhibit #1). Such conviction was not disputed by Dr. Coolahan.

CONCLUSIONS OF LAW

From the foregoing facts the Commission concluded that the Respondent, John Francis Coolahan, MD, had been found guilty of a crime involving moral turpitude and was thus subject to the disciplinary procedures of the Commission under Article 43, Section 130 (h) of the Annotated Code of Maryland, 1971 Replacement Volume.

ORDER

Upon the foregoing findings of fact and conclusions of law it is, the 28th day of April, 1971, by the Commission on Medical Discipline of Maryland, ORDERED, that the license heretofore issued by the Board of Medical Examiners of Maryland to the Respondent, John Francis Coolahan, to practice medicine and surgery in the State of Maryland, be and the same is hereby suspended indefinitely, with the right to the Respondent to apply for reinstatement of said license at any time after six (6) months from the date of this order, and, be it further ORDERED that a copy of the foregoing findings of fact, conclusions of law and order be filed with the Maryland State Board of Medical Examiners in accordance with the provisions of Article 43, Section 130 (k) of the Annotated Code of Maryland, 1971 Replacement Volume.

/s/ JOHN M. DENNIS, MD, Chairman

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ASUNCION L. PALAFOX, MD

Upon the complaint of the Commission on Medical Discipline of Maryland, the Commission directed the Respondent, Asuncion L. Palafox, MD, a person licensed to practice medicine and surgery in Maryland by the Maryland State Board of Medical Examiners, to answer charges of having willfully made and filed false reports or records in her practice as a physician; of having made willful misrepresentation in treatments; having grossfully, willfully and continuously over-charged for professional services, including filing of false statements for collection of fees for which services were not rendered; and being professionally or mentally incompetent. After due notice to the Respondent, a hearing was held on Thursday, May 6, 1971 before the Commission on Medical Discipline of Maryland. The Respondent appeared and was represented by A. David Gomborov, Esq., her counsel.

FINDINGS OF FACT

The Commission heard testimony from Mr. Edward W. Hasson, Vice President of Maryland Blue Shield; Arthur E. Cocco, MD, Chairman, Peer Review Committee, Medical and Chirurgical Faculty of Maryland; and from the Respondent. In addition, there were introduced as Commission's Exhibit ten reports submitted by Dr. Palafox to Maryland Blue Shield during the year 1970 in support of charges made by her to patients covered by various Blue Shield plans. Furthermore, there were introduced as Exhibits on behalf of the Respondent notes made by her as to her treatment of some of the patients referred to in the reports, various x-rays which she had taken of these patients and EKG tracings which she had taken from these patients. From the evidence presented, the Commission made the following findings of fact:

1) In each case represented by the ten Commission Exhibits, Dr. Palafox had charged, or attempted to charge excessive fees.
2) That Dr. Palafox had charged, or attempted to charge one or more patients for x-rays which were actually blank.
3) That most of the x-rays submitted to the Commission by Dr. Palafox were of such poor quality as to have little or no medical value.
4) That Dr. Palafox's diagnostic work-ups were inadequate. That she had made unverified diagnosis, which could have been verified with further study.
5) That she had failed to follow through with diagnostic impressions.
6) That in her treatment of patients she had used drugs or treatments which by general local practice are deemed to be contraindicated.
7) That in her treatment of patients she had used drugs or treatments which by general local practice are deemed to be irrelevant.
8) That she had treated patients for conditions, the existence of which were not adequately verified.

CONCLUSIONS OF LAW

From the aforegoing facts the Commission concluded that the Respondent, Asuncion L. Palafox, MD, had been guilty of 1) willfully making and filing false reports or records in her practice as a physician; 2) gross and willful and continued over-charging for professional services, and; 3) professional incompetency and that she was thus subject to the disciplinary procedures of the Commission under Article 43, Section 130 (h) of the Annotated Code of Maryland, 1971 Replacement Volume.

ORDER

Upon the aforegoing findings of fact and conclusion of law it is, this 19th day of May, 1971, by the Commission on

Medical Discipline of Maryland, ORDERED, that the license heretofore issued by the Board of Medical Examiners of Maryland to the Respondent, Asuncion L. Palafox, to practice medicine and surgery in the State of Maryland, be and the same is hereby revoked, and, be it further ORDERED that a copy of the aforegoing findings of fact, conclusions of law and order be filed with the Maryland State Board of Medical Examiners in accordance with the provisions of Article 43, Section 130 (k) of the Annotated Code of Maryland, 1971 Replacement Volume.

/s/ JOHN M. DENNIS, MD, Chairman

●

HAROLD V. HARBOLD, MD

Upon the complaint of the Commission on Medical Discipline of Maryland, the Commission directed the respondent, HAROLD V. HARBOLD, MD, a physician licensed by the Board of Medical Examiners of the State of Maryland, to answer charges of 1) abandonment of a patient, and 2) professional or mental incompetency. After due notice to the respondent, a hearing was held on Thursday, May 20, 1971, before the Commission on Medical Discipline. The respondent was present, without counsel.

FINDINGS OF FACT

The Commission heard testimony from the respondent and from Albert B. Bradley, MD, the present principal physician at the Gould Convalesarium. From the testimony, the Commission concluded that the respondent, in his capacity as principal physician of Gould Convalesarium from 1967 through 1970, was unaware of the duties of a principal physician as set forth in the regulations of the Maryland State Department of Health, failed to fulfill many of these duties and further, was unaware of the requirement that he report the existence of communicable diseases as set forth in the regulations of the Maryland State Department of Health. There was no evidence presented to the Commission from which it could conclude that Dr. Harbold was in any manner incompetent in the treatment of his patients. Further, from the testimony of Drs. Harbold and Bradley, it was clear to the Commission that Dr. Harbold had made arrangements with Dr. Bradley to care for his patients when he, Dr. Harbold, went on vacation on August 3, 1970, that such arrangements had been made well in advance of that date and there, therefore, was no evidence that Dr. Harbold had abandoned any of his patients.

CONCLUSIONS OF LAW

On the basis of the foregoing Findings of Fact the Commission concluded that the respondent was guilty of professional incompetency in failing to be aware of his duties while acting as the principal physician of Gould Convalesarium during the period 1967 through 1970, which such findings brings the respondent within the disciplinary powers of the Commission under the provisions of Article 43, Section 130 (h) of the Annotated Code of Maryland, 1971 Replacement Volume.

ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 24th day of May, 1971, by the Commission on Medical Discipline of Maryland.

ORDERED, that Dr. Harold V. Harbold be and he is hereby reprimanded and, be it further,

ORDERED, that a copy of the foregoing Findings of Fact, Conclusions of Law and this Order be filed with the Board of Medical Examiners of the State of Maryland and that a copy hereof be mailed to the respondent forthwith, pursuant to the provisions of Article 43, Section 130 (k) of the Annotated Code of Maryland, 1971 Replacement Volume.

/s/ JOHN M. DENNIS, MD, Chairman

●

JEROME GABER, MD

Upon the complaint of the Commission on Medical Discipline of Maryland, the Commission directed the respondent, Jerome Gaber, MD, a person licensed to practice medicine and surgery in the State of Maryland by the Maryland State Board of Medical Examiners, to answer charges of having willfully made and filed false reports and records in his practice as a physician; of having made willful misrepresentation in treatments; having grossfully, willfully and continuously overcharged for professional services, including filing of false statements for collection of fees for which services were not rendered, and; being professionally or mentally incompetent. After due notice to the respondent a hearing was held on Thursday, September 9, 1971 before the Commission on Medical Discipline of Maryland. The respondent appeared and was represented by Seymour Sureff, Esq. his counsel.

FINDINGS OF FACT

The Commission heard testimony from Mr. Edward W. Hasson, Vice-President of Maryland Blue Shield; Arthur E. Cocco, MD, Chairman, Peer Review Committee, Medical and Chirurgical Faculty of Maryland; and from the respondent. In addition, there were introduced as Commission's Exhibits, numerous claims forms submitted by Dr. Gaber to Maryland Blue Shield. There were introduced in evidence, on behalf of the respondent, a letter from William N. Fitzpatrick, MD, testifying to the respondent's mental competency and copies of numerous other letters from physicians and patients of Dr. Gaber certifying to his general medical competency. From the evidence presented, the Commission made the following findings of fact:

1) That the evidence before it was insufficient to enable the Commission to conclude that Dr. Gaber had willfully made or filed false reports or records in his practice as a physician.

2) That there was no evidence from which the Commission could conclude that Dr. Gaber had been guilty of willful misrepresentation in treatments.

3) That there was no evidence from which the Commission could conclude that Dr. Gaber had been guilty of gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services were not rendered.

4) That there was no evidence before the Commission from which it could in any way conclude that Dr. Gaber was mentally incompetent.

5) That the quality of the notes and records kept by Dr. Gaber in his practice as a physician in the early part of 1970 and prior thereto was substantially below that required by contemporary standards in the local medical community. The Commission further found that the notes and records presently maintained by Dr. Gaber met this standard.

CONCLUSIONS OF LAW

From the foregoing facts the Commission concluded that the respondent, Jerome Gaber, MD, was not guilty of 1) willfully making and filing false reports or records, in his practice as a physician; 2) willful misrepresentation in treatments; 3) gross and willful and continued overcharging for professional services, including filing of false statements for collection of fees for which services were not rendered; or 4) mental incompetency. From the evidence before it with respect to the quality of the notes and records maintaind by Dr. Gaber in the early part of 1970, the Commission concluded that they were of such poor quality as to amount to professional incompetency on the part of Dr. Gaber and that he was thus subject to the disciplinary procedures of the Commission under Article 43, Section 130 (h) of the Annotated Code of Maryland, 1971 Replacement Volume.

ORDER

Upon the foregoing findings of fact and conclusions of law it is, this 17th day of September 1971, by the Commission on Medical Discipline of Maryland, ORDERED, that Jerome Gaber, MD, be and is here REPRIMANDED; and, be it further ORDERED that a copy of the foregoing Findings of Fact, Conclusions of Law and this Order be filed with the Maryland State Board of Medical Examiners in accordance with the provisions of Article 43, Section 130 (k) of the Annotated Code of Maryland, 1971 Replacement Volume.

/s/ JOHN M. DENNIS, MD, Chairman

*"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

# Should nongovernment scientists and physicians play a role in drug regulation?

# Opinion

**Results of a questionnaire to 7000 physicians:**

82.8%
**Physicians should play a role**

78.3%
**Independent scientists should play a role**

69.8%
**Medical academicians should play a role**

Opinion & Dialogue

# Dialog

## Should nongovernment scientists and physicians play a role in drug regulation?

### Doctor of Medicine

**Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant**

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized, in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications line in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn, could notify the physicians in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: if drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

# ue

## Maker of Medicine



**Henry W. Gadsden, Chairman & Chief Executive Officer, Merck & Co., Inc.**

In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

## Opinion & Dialogue

**What is your opinion, doctor?**
**We would welcome your comments.**

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**Usage In Children:** Not recommended for use in children under 12 years of age.

**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

**Adverse Reactions: Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

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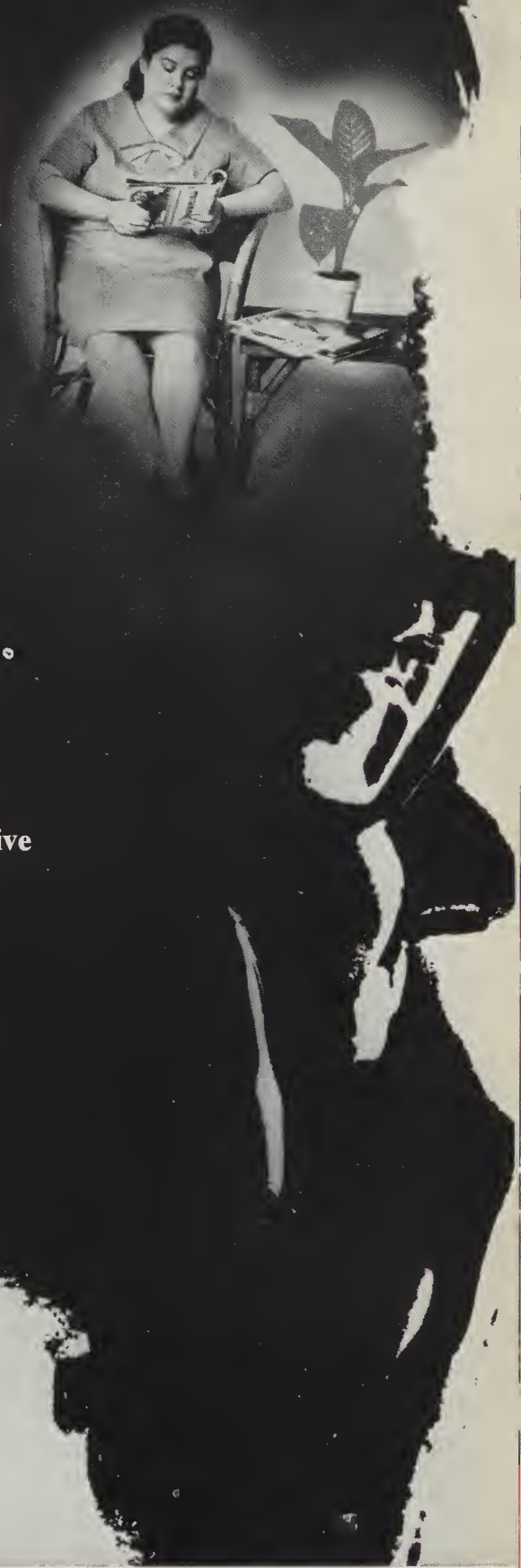
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*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

**rehabilitation medicine**

# FACIAL NERVE PALSY: CLINICAL AND ELECTRODIAGNOSTIC DESCRIPTION

**ROBERT C. STEINMAN, MD**
**Director, Dept. of Physical Medicine**
**Prince George's General Hospital**
**Cheverly, Md 20785**

It has been asserted repeatedly that paralysis of the facial nerve is the most common mononeuropathy.[1,3] Cawthorne[3] likewise emphasizes that it is more frequently paralyzed than any other motor nerve and pointed out that it also has the longest course in a bony canal compared to any other nerve.

Various classifications have been proposed. In one classification McGovern and Fitz-Hugh presented a method based principally on anatomical location.[2]

1) Supranuclear lesions:
   Intracranial tumors
   Vascular accidents, etc
2) Nuclear lesions:
   a) Congenital nuclear aplasia
   b) Pontine lesions
      1) Tumor
      2) Poliomyelitis
      3) Inflammations
      4) Syringobulbia
3) Posterior cranial fossa disease:
   a) Cerebello–pontine angle tumors
   b) Meningeal lesions
   c) Tumors of petrous ridge
4) Paralysis from injury or disease of temporal bone:
   a) Neuromas
   b) Fractures
   c) Inflammation
   d) Surgical entry
5) Paralysis from injury or disease of the extra-temporal course of the nerve:
   a) Parotid tumors
   b) Birth injuries
   c) Trauma
      1) Surgical
      2) Other
   d) Uveo-parotid syndrome
6) Bell's palsy

These authors also state that facial paralysis constitutes 75% of facial nerve lesions and that 90% of peripheral facial paralysis is caused by lesions within the temporal bone.

According to Taverner[4] in order to make a diagnosis of Bell's palsy, the following four criteria must be met:

1) Sudden onset of complete or partial paralysis of the muscles of expression on one side of the face.
2) Absence of any symptoms or signs of any other disease of the central nervous system.
3) Absence of any symptoms or signs of any disease of the ear or posterior fossa.
4) Absence of herpetic vesicles.

There may be no pain with Bell's palsy, but some patients frequently complain of pain in the ipsilateral ear and mastoid area. Others have discomfort over the temple, face, and jaw. It is not unusual for the pain to precede the paralysis by days and it may last five to ten or even more days. Numbness in the face is a very common subjective complaint but this is never borne out in testing for pain, touch, or temperature. It is thought that this subjective numbness may be related to the loss of sense of position and movement in the facial muscle.

The complaint of impairment of the sensation of taste is infrequent in Bell's palsy. In other words, typically the patient does not complain

of this even if questioned, because the lesion is usually distal to the chorda tympani. If taste is affected, one can assume the existence of proximal neuropathy at or above the level of the chorda tympani nerve, as proximal as the geniculate ganglion, or even more central. We have not found any extra-helpful information from testing for the four fundamental flavors of sweet, salty, sour, and bitter. Thus we merely ask the patients about this problem. We have not used electrogustometry either, although it has been very helpful according to some,[5] and is even considered as an aid to prognostication.[6] Others have denied its usefulness,[7] pointing out problems of interpretation. Some of these problems are due to numerous variables including the fact that coated tongues, hot beverages, smoking, alcohol and the like can influence the values obtained. In children and those of low intelligence, interpretation is very difficult.

The onset of paresis is often rapid, and may be first noted when the patient arises after a night's sleep, which is quite common in our experience. It may commence with a much more gradual picture, progressing during a 12- to 24-hour period. The patient may notice "numbness" in the face, but upon washing up and looking in the mirror, disfigurement is evident. While attempting to drink, liquid drools out of the affected corner of the mouth and brushing the teeth is difficult. Eating results in food lodging between the teeth and the cheek. Hyperacusis is an occasional complaint offered by the patient, but more often nothing is said until the examiner questions him about any alterations of hearing.

The explanation for the exaggerated acuity of hearing lies in the impaired function of the stapedius muscle, which is also supplied by the facial nerve. Its normal function is to dampen the oscillations of the auditory ossicles. When paralyzed it allows more vigorous oscillations, with resultant hyperacusis if the lesion is proximal to the branch innervating the stapedius muscle. Impedance audiometry is useful here to measure the functional ability of the stapedius muscle.

The inability to blink and close the eye is significant because the protective reflex is lost. Excess tearing is a complaint; this is really not due to an overabundance of tears, but rather to the fact that the tears stream down the face instead of down the lachrymal duct. This occurs because of the drooping of the lower lid, and also because the tear duct opening itself loses its normal round circumference and becomes elliptical, altering the normal dynamics. If Bell's palsy causes any alteration in the supply of tears from the lachrymal gland, it is a decrease in the amount of tears and even possibly a loss of tears. Even then a "dry eye" does not occur, because glands in the fornix lubricate the conjunctiva, and can continue to moisten the eyeball, though the lachrymal gland itself has ceased to secrete tears.[8]

Cawthorne[8] uses a modification of Schirmer's test for tears. Here a strip of filter paper 0.5 cm wide and 2 cm long is hooked into the lower lid of each eye. Each strip is fully moistened within five minutes, when lachrymation is normal. He has the patient sniff from an ammonia bottle, thus stimulating a more rapid flow of tears if the nerve is intact. When it is not, the filter paper strip remains dry on the paralyzed side.

The paresis may be so mild that it is noted only on vigorous smiling and at other attempts at facial expression. At repose even a fairly marked paralysis may be barely noted because the tone in the facial muscles may be good. This is especially true in the younger adult or child. Nevertheless once expression is registered, such as a laugh, frown, or smile, the contrast is readily noted as the face is pulled over towards the healthy side. Of course when the lips are pursed the mouth is pushed toward the affected side. In the elderly, tone is much more affected; the deformity in this group may be very marked, even at rest.

Occasionally, when a bilateral mild involvement is present, the facial paresis is hard to detect because symmetry is maintained. This also happens when the second side becomes involved subsequent to a unilateral lesion. Here one may be deceived into thinking that there is improvement of the original paretic side, because once again the face looks more symmetrical.

Bell's palsy spares no age. We have seen it in infants and the elderly. It has even been reported at age one month and four days.[9]

Why does Bell's palsy develop? No one seems really to know. The fact that this nerve has the longest course through a bony canal of any nerve in the body seems to be accepted most widely as an important factor. It has been said that initial dilatation of the vasa nervorum occurs, followed by edema and swelling, and then by secondary ischemia within the tight and strong nerve sheath. Thus loss of function can occur under these circumstances. A very different viewpoint has been advanced by Sade,[22] who feels that infection may migrate from the external or middle ear, along the course of the chorda tympani to the facial nerve, causing

palsy. Its occurrence may even be epidemic,[16] supporting a possible viral infectious etiology.

Numerous writers emphasize the generally accepted idea that the prognosis is excellent and that the great majority of patients will recover completely, in the range of 70% to 90%. We do not disagree. Even if we accept these figures, there is room for doubt and anxiety by and for the individual patient. His chances are 10% to 30% for a less than satisfactory result. Almost anyone so stricken is concerned. If the physician can allay anxiety and fear, and if he can promptly assure a particular patient, after evaluation, that his prognosis is excellent, then a contribution has been made to the patient's welfare.

In addition, if he can recognize the signs of poor prognosis, in which severe damage is occurring, he can help identify that small number of perhaps 5% to 10% of patients for whom decompression surgery may be indicated. The means of accomplishing this readily is electrodiagnostic testing. With this evaluation we can indicate the prognosis of facial palsy in order to accomplish the following:

1) Relief of anxiety and concern of the patient, the family, and of the physician for those who will do well and for whom no therapy of any type is needed.

2) Identify those whose course will be prolonged and for whom recovery will be incomplete and some therapy is therefore indicated.

3) Quickly identify the small group of 5% to 10% who need decompressive surgery.

4) Aid in the diagnosis of those paralyses that are not simply a Bell's palsy, for example:

Guillain-Barré syndrome
Polyneuropathy, for example in a diabetic
Sarcoidosis
Tumor of the nerve
Uremia
Periarteritis nodosa

A series of five tests can be done. They are described briefly here. These electrodiagnostic tests are based on the fact that the muscles examined are small and superficial, and the nerve and its branches are readily accessible, close to the surface!

1. **Nerve excitability:** The facial nerve is stimulated with an impulse of nonvarying duration (one msec). The amount of current necessary to produce a visible, definite, minimal contraction is measured in ma. We compare the affected side to the apparently healthy side, and also do serial testing over a period of days. If simple conduction block (neurapraxia) has occurred proximal to the point of stimulus, there will be no (or little) change in excitability. If partial to complete Wallerian degeneration is occurring, in three to five days the excitability decreases, and thus many more milliamps are needed to produce a contraction.

2. **Chronaxy:** Chronaxy is the minimum time necessary for an electrical stimulus of twice the threshold strength (rheobase) to produce a minimal contraction of a muscle. I will not describe this in detail since we do not find it useful. However, since it is often mentioned in the literature, I will simply state that it is a direct electrical stimulation of the muscle itself. I don't find it helpful because even if severe denervation has occurred, the chronaxy does not start to rise rapidly until ten to 14 days have passed, and it is not a useful type of study to prognosticate recovery.

3. **Electromyography (EMG):** By placing a needle electrode within the actual muscle substance, we can, with suitable apparatus, record changes of potential occurring in these fibers. We use the coaxial needle where differences of potential are measured between the active central core and the needle casing, the two being separated by suitable insulation. We actually measure and record the depolarization of muscle fibers for visible and auditory analysis.

4. **Facial nerve latency:** This is not an actual conduction velocity test. It is the time elapsed from electrical stimulation of the facial nerve to the start of the contraction of the particular muscles supplied. This latency should not be over four to five ms.

5. **Strength-duration curve testing:** This is based on the fact that the degree of response depends on the strength of the exciting stimulus and also on its duration. In healthy muscle, with normal nerve supply, the nerve is very excitable. When denervation exists we actually stimulate the muscle cells themselves, and since the muscle is then much less excitable, more and more intensity of current is needed as the stimulus duration is shortened. This procedure is widely used in Europe, but is not so enthusiastically utilized in this country. It adds unnecessarily to the time needed for the examination, and provides information readily obtained by other techniques.

We therefore generally use only nerve excitability, EMG, and facial nerve latency in order to study the nerve by electrical means. Nerve excitability is a very sensitive indicator and the easiest test to perform. The ma used may climb rapidly as function is lost; ie, as the nerve excitability diminishes. Some feel that if a dif-

ference of three ma develops between the two sides, surgery may be indicated. However we think this attitude is too rigid and we do not rely on this test alone.

There are occasions when nerve excitability has disappeared, but facial nerve latency can still be obtained and EMG will even demonstrate that some active potentials can be elicited on voluntary effort. On the other hand no active potentials may be found, and yet excitability, and more probably nerve latency, can be elicited. With EMG, polyphasic forms can be noticed in five to seven days. Fibrillation potentials, an unfavorable finding, are definitely noticed before 14 days. It is obviously possible to have many fibrillation potentials, indicating Wallerian degeneration of some axons, along with voluntary potentials of diminished numbers, indicating function remaining in other axons and the muscle fibers they control.

We routinely test excitability and nerve latency of the frontalis muscle, orbicularis oris at the angle of the mouth and of the triangularis muscle. EMG is then done on the same muscles. The orbicularis oculi, mentalis and posterior auricularis and even the platysma may also be examined occasionally. We usually stimulate the nerve where it emerges from the stylomastoid foramen. Even after the facial nerve has been severed, it maintains excitability for three to four days; thus, relying on early evaluation by this means can be misleading. We prefer to test very promptly, but usually may not see the patient until the third or fourth day. If the findings are favorable by the fifth day, we retest the patient between the 12th and 14th days unless it is convenient for him to be available for one or two more nerve excitability tests before that time. It is inadvisable to be too confident in an apparent good prognosis on the seventh day, since it is simply too early. We have seen patients go on from apparent favorable indicators on day number seven to complete loss of excitability and obvious Wallerian degeneration by day number 14.

Another source of error later on is related to the fact that neurotization[11] may take place from across the midline, even as early as 16 days. In other words the normal unaffected nerve may send axons across the midline to attempt reinnervation of the paralyzed muscles. This can lead to false "evidence" suggesting recovery of the affected nerve; consequently testing too close to the midline must be avoided. In addition one author[10] insists that about one fifth of patients have bilateral peripheral innervation of the lower face.

In testing for facial paralysis, we may pick up bilateral disease suggesting Guillain-Barré syndrome, Boeck's sarcoid, or even diabetes. In cancer of the nerve itself, or compression by a slow-growing neoplasm, the conduction velocity may be remarkably slow; thus the facial nerve latency is extremely prolonged.

If we find evidence of good prognosis we usually suggest no treatment at all. No electrical stimulation therapy is given, no steroids are advocated, and no exercises are started. Assurance that recovery will very likely be well on its way in three to four weeks (which applies to most patients) is given. In these patients, nerve excitability has decreased slightly, facial nerve latency has not been markedly prolonged, remaining less than five to six ms and there are no (or few) denervation potentials seen on EMG.

In those cases where excitability is completely lost, where no facial nerve latency can be evoked, or where it is very delayed (ten to 12 ms or more), and when few or no voluntary potentials are noted and many denervation potentials are seen, surgical decompression is considered and the patient is referred to an otolaryngologist and (if possible) to a neurologist. There are great differences of opinion about what to do in this type of patient. According to one author[12] we should wait 30 or more days before surgery. Another[13] feels that we should wait 90 days before referring to the surgeon. At the other pole are those who advocate immediate surgery when excitability diminishes markedly.[14] A neurologist on the other hand stated that he would never send (nor has he ever sent) a patient for surgical decompression.[15] A further opinion[8] is to refer the patient to the otolaryngologist no later than two weeks after onset.

The other group of patients, those with unfavorable findings, includes those in whom the nerve excitability decreased to such an extent that we have to use more than four to five ma above the initial value for nerve excitability to stimulate the nerve. Typically nerve latency may be prolonged over 6 ms and, in addition, some denervation potentials are seen along with polyphasics and a marked decrease in the normal motor unit output on voluntary contraction.

Sometimes no voluntary units are seen on EMG. In these patients we prescribe electrical stimulation which is started in the physical medicine clinic or hospital and continued at home. Steroids, if not previously used, may be prescribed.[17] However ACTH intramuscularly is preferred by some.[5,15] Injection of steroid into the stylomastoid foramen has also been used.[17] Exercises are taught, heat and massage are prescribed, and are continued at home. Repeating

electrodiagnostic tests every three to four weeks may help delineate the patient's course. Usually such patients (with moderately to severely diminished excitability) will take from six to nine months to improve.

Almost always, the lower part of the face recovers more slowly and less completely than the upper. The eye always recovers some closure, although blink may be slow.[18] Until good blinking occurs, eye care is needed. The simplest aids include plastic eye shields, castor oil, or artificial tears, one drop in each eye several times a day and even a metal eyepatch occasionally. Some patients[18] may develop severe epiphora, conjunctivitis, punctate keratitis, corneal abrasions, and even more severe ocular problems. Normal use of saline solution is helpful, but sometimes a temporary partial tarsorrhaphy is needed. Prolonged use of cortisone or antibiotic drops should be avoided.[19] Artificial tears can be used frequently.

The use of electrical stimulation is empirical. We may even use it on those with an excellent prognosis if they are very apprehensive. To all patients, we state that it is not definite that the recommended treatment will help, and that some authorities even think it is useless. We can see no harm in its use, and some of the patients do feel better attempting to do something for themselves, and it may help prevent atrophy.

With respect to those for whom the prognosis is excellent, predictive results have been uniformly consistent. The principal caution is not to give a prognosis until the 12th to 14th day. At that point we can be quite reassuring about the outcome if the findings are satisfactory. For the moderately or severely afflicted group, results can be predicted fairly well in that there will be a prolonged course of six to nine months, and sometimes more, before satisfactory recovery occurs.

The group with total loss of excitability and complete Wallerian degeneration is the most troublesome. We have seen seven patients through decompressive surgery of the facial canal. The responses were not predictable and though I still advocate the surgery for certain cases, there is much argument about whether to operate at all and, if so, when to operate and what type of surgery to do. A recent report indicated enthusiasm for decompression, in that a group undergoing surgery had an average 73% recovery rate compared to 14% in a group who refused surgery.[20] Another investigator did not encounter favorable influence on the course of Bell's palsy if decompression was performed as late as the second or third week after onset.[21]

Among the complications and sequelae which may occur after Bell's palsy were those mentioned concerning the eye above. In addition associated movements, contractures, crocodile tears, gustatory sweating (auriculotemporal syndrome), parageusia, and postparalytic hemispasm of the face may occur. It is for the prevention of such problems that ACTH early, and surgical intervention for carefully selected patients, may be indicated for those who are most severely affected.

It is hoped that the author's effort in reviewing his own clinical experiences and conclusions and those of others will contribute to the reader's understanding and management of facial nerve paralysis.

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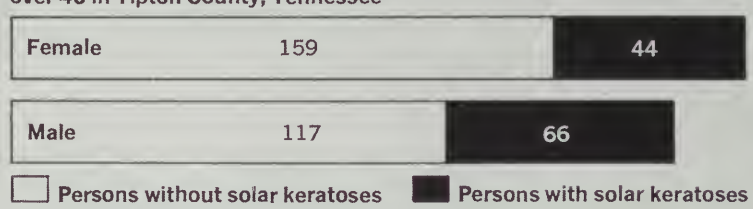
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**Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee**




*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



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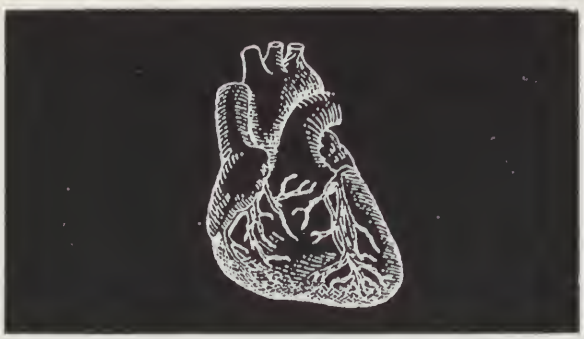
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# CARDIAL TAMPONADE AND CONSTRICTIVE PERICARDITIS TREATMENT

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In the preceding article in this series, pathophysiology, clinical signs and symptoms, and etiology of cardiac tamponade due to pericardial effusion and constrictive pericarditis were discussed. We shall now consider treatment of these conditions.

## Tamponade

The only treatment is removal of the fluid. If the patient is moribund, pericardiocentesis is carried out as an emergency. More often the patient should be moved to the operating suite, intensive care area or cardiac catheterization laboratory. Of the several approaches to the pericardium, the xiphisternal is the safest. The patient rests supine with the thorax elevated 45 degrees. The skin and subcutaneous tissues a few mm from the xiphisternum are cleansed and infiltrated, and then pierced with the tip of a No. 11 blade. An 18T needle is advanced posteriorly until its tip has negotiated the bony margin of the thorax. The needle is then advanced close to the midline with a slight posterior tilt until the pericardium is reached. If there is much effusion, little or no cardiac pulsation will be felt. The needle is advanced through the pericardium, usually with a palpable sensation.

A conventional ECG lead should be monitored throughout the procedure. If it is absolutely certain that all equipment is properly grounded, the position of the needle tip can be monitored by a direct ECG lead. A cable connects the needle hub and an indifferent electrode (eg, a limb lead) to the electrocardiograph which is set in position "V." If the needle tip touches the epicardium a large ST segment elevation occurs in the needle lead, and a smaller one in the conventional lead. Also ventricular extrasystoles may be provoked. When these phenomena occur, the needle should not be advanced further, but should be withdrawn slowly and carefully until the ST segments are again isoelectric.

As soon as the pericardium is entered, a sample is aspirated, and if bloody its hematocrit and clotting time are compared with those of the patient's blood. Hemorrhagic fluid rarely clots and almost always has a lower hematocrit than venous blood. Pericardial pressure should then be measured with a manometer after which samples should be obtained for bacteriology, chemistry, and cytology. Removal of the first 50-200 ml of fluid usually produces prompt relief because of the steep pericardial pressure volume curve. Venous pressure and pulsus paradoxus decrease and the arterial pulses become full. Pericardial fluid is aspirated as long as it comes off easily, and preferably until the pericardial pressure is zero or less. No elaborate precautions to prevent air aspiration are needed; indeed, introduction of a volume of air or $CO_2$ equal to less than half the aspirated fluid volume is useful to delineate the pericardium in subsequent chest roentgenographs.

Sometimes it is desirable to leave a small tube in the pericardium. Chemotherapeutic agents may be instilled into the pericardial sac. A chest roentgenograph is obtained at the end of the

procedure. Appropriate systemic antibiotic therapy is commenced and, if tuberculosis is a reasonable possibility, steroids may be administered as well.

If a delay in initiating pericardiocentesis is inevitable, the circulation can be temporarily sustained by infusion of isoproterenol together with volume expansion by means of dextran blood or saline. Isoproterenol is started at two-to-four micrograms per minute and increased until perceptible effects on the pulse and pressure are evident. Recurrence of tamponade may require repetition of pericardiocentesis, but surgical drainage may then be preferable. In traumatic cases recurrence after one or two successful aspirations is an indication for surgical drainage. When tissue diagnosis is important and a physician experienced in the technique of pericardiocentesis is not available, the pericardium can simply be drained and biopsied under local anesthesia after excision of the xiphoid process.

### Constrictive Pericarditis

Once this diagnosis is established, the patient should be referred to a thoracic surgeon for pericardiectomy. Patients improve following digitalization because of the frequent myocardial involvement associated. Tachycardia secondary to atrial fibrillation responds well to digitalis, as in heart failure. These measures alone produce diuresis, but it is usually advisable to administer diuretics as well. These are given in high dosage for as long as they are effective and serum sodium and chloride levels are not excessively depressed. Serum potassium must be maintained at normal levels by means of oral potassium chloride administration, and salt intake should be moderately reduced. Because of liver congestion, alcohol and other hepatic toxins must be forbidden. These measures may be employed to effect an immediate improvement and to prepare the patient for pericardiectomy. They are also remarkably successful for variable periods in patients who are unwilling to undergo operation, but in these circumstances slow progression of physiologic decompensation invariably occurs.

Pericardiectomy is now a safe operation. In a young individual without pericardial calcification, cardiac enlargement, or atrial fibrillation the mortality is virtually zero. Thus the operation is urgently indicated in subacute constrictive pericarditis. In chronic calcific constrictive pericarditis, the operative risk is 5% to 10% in the hands of experienced cardiac surgeons. Pericardiectomy is not an open heart procedure, but full cardio-pulmonary bypass facilities should be immediately available to deal with cardiac trauma, evidence of which may appear suddenly at any time during the operation.

Several months elapse after operation before recovery is complete, especially in the more chronic cases. Venous pressure is reduced somewhat immediately following operation but only slowly returns to normal. Digitalis and diuretics may be required for several months to control edema and effusions. In the most chronic cases with heavy calcification and long standing congestion, the aim is improvement rather than cure. The results in these patients are limited by myocardial involvement, hepatic insufficiency, chronic pulmonary congestion, and pleural disease.

Cardiac compression secondary to malignant disease should be managed as conservatively as possible. Pericardiocentesis and the instillation of cancer chemotherapeutic agents may control the process in some patients. In others it may be necessary to construct a pericardiopleural window to drain the pericardium via the pleural space. There is little to be done for patients with constrictive pericarditis secondary to malignancy without an element of pericardial effusion. Surgeons are generally appropriately reluctant to perform pericardiectomy under such circumstances.

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**occupational and environmental health news**

# PREVENTIVE ASPECTS OF OCCUPATIONAL MEDICINE PRACTICE

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An Occupational Health Program is defined by the American Medical Association as a program, provided usually by management, to deal constructively with the health of employees in relation to their work. Broadly, occupational medicine is that branch of medicine practiced by physicians in meeting medical problems and needs within occupational health programs.* Certification of specialists in the field of occupational medicine is the responsibility of the American Board of Preventive Medicine. In June 1955 the Council of Medical Education and Hospitals of the American Medical Association authorized certification by the Board of Specialists in Occupational Medicine.

In addition to furnishing rapid, competent treatment of injuries and illnesses occurring in the work place, maintenance of a healthy and productive work force is a primary concern of the occupational medicine specialist. It was this role of prevention of illness and disease that led to recognition of occupational medicine by the American Board of Preventive Medicine.

Preventive programs in occupational medical practice have traditionally been designed to achieve primary benefit to the employer by reducing injury and illness on the job. However there are many other aspects to these programs that benefit the worker and also the community. These secondary benefits are increasing in importance as the costs of medical care rise and new concepts for health maintenance and delivery of medical care are being explored. A review of four preventive medicine programs that comprise a part of almost every occupational medicine practice will illustrate this concept of primary and secondary benefits.

**Pre-Employment Examinations:** The extent of these examinations, conducted as part of the hiring process, varies considerably. Whether they are done by a physician, industrial nurse, or paramedic, they are designed to select a healthy worker who can perform his job safely. Primarily they allow the employer to match the employee to a job within his physical capability, preventing injury and financial loss.

These examinations can be looked upon as multiphasic screening examinations of a presumably healthy population. Hypertension, diabetes, kidney disease, malignancies, and hearing or visual defects are often detected for the first time. Communicable diseases, such as tuberculosis and venereal disease, are often found. The individual examined is highly motivated to seek medical treatment in order to gain approval for employment.

**Periodic Physical Examinations:** These examinations, done at predetermined intervals, vary from a single laboratory exam to a complete evaluation of multiple organ systems. Their primary value is to prevent disease or inury caused by the cumulative effects of some hazard in the industrial environment. Periodic evaluations are also used to determine if the worker still has the physical capacity to continue in his job without risk to himself or his fellow workers.

The worker benefits directly from the protection he gains from hazards in the work place. Further secondary gains come from initial detection of nonindustrial diseases, such as glaucoma, diabetes, hypertension, and visual or

**AMA House of Delegates statement on scope, objectives, and functions of occupational health programs, June 1960.*

hearing defects. The progression of an already identified disease can be measured and the worker advised to seek further treatment from his family physician or clinic. The setting of the periodic examination is ideal for health education. Diet, weight control, smoking, and alcoholism are topics that can be reviewed through discussion or pamphlets.

**Evaluation After or During Absence from Work Due to Illness:** Examination to determine that the worker has recovered sufficiently from his illness to be able to return to his job without hazard is often done.

The high cost of benefits for sickness to workers in many industries makes it advisable to obtain periodic evaluations during any prolonged illness. The employer, as primary insurer, may request examination to determine that the worker is indeed ill and obtaining medical treatment for his illness. The primary goal is to decrease the employer's costs for illness and return the worker to productivity as soon as he has completed treatment. This type of examination is confined to the specific disease or injury claimed by the patient.

Often the patient has not completed the prescribed treatment given by his physician, or has not returned to him for follow-up. The worker is requested to complete his treatment before returning to work. This benefits both the worker and his treating physician. Another secondary gain is education and explanation to the worker of treatment received in a busy hospital emergency room or outpatient clinic. Communication between the evaluating industrial physician and the worker's physician very often benefits all concerned and reduces misunderstanding of the worker's illness and job requirements, resulting in a smoother, more rapid return to work. In addition many workers are unsure of their benefits under employer's insurance plans, private insurers, and Social Security. These can be explained during illness evaluations.

**Programs For Alcohol and Other Drugs of Abuse:** Many industrial medicine programs include recognition of alcoholism as a disease entity and stress early detection and referral for treatment. Programs for detection of drug abusers by urinalysis screening techniques are developing. These programs are designed primarily to reduce time lost from work and prevent injury of the worker on the job.

Recognition of these problems as medical problems has the secondary benefit of obtaining early and adequate treatment. In addition, the worker in most cases keeps his job, aiding in his recovery by providing security and income for his family.

It has become more and more evident that we cannot separate a man's illness from his environment. The work environment plays a very large role both as a source of potential hazard and source of security. In this respect the secondary benefits of occupational medicine may be expected to play a greater role in the total health care of the worker in the near future.


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## Filthy Lucre–Dirty Money

Money is truly dirty said two monetary-minded physicians in a recent issue of the *Journal of the American Medical Association.*

The medical sleuths with numismatic leanings borrowed 62 pennies, 38 nickels, 27 dimes, 33 quarters, and 50 paper bills of small denomination, with no discrimination as to age, sex, color, or religion of the lender, so the results would be unbiased. They then cultured the coins and bills.

They discovered that 13% of the coins and 42% of the bills were contaminated by potentially disease-causing bacteria. Pennies, nickels, and small denomination paper bills were more often contaminated than larger coins and bills, a fact they explained was logically due to the rapid turnover and frequent exchange of small coins and bills.

The investigators offered these tongue-in-cheek Rules to Stay Sterile By:

1) "Keep your money in the bank;

2) If you must carry money, carry only large bills, preferably the $50 and $100 denominations;

3) Don't make change;

4) Keep your hands out of your pockets;

5) Get rid of your money rapidly. (This isn't much of a problem for most of us); and

6) Campaign against piggy banks. (Particularly for children who will be contaminated soon enough anyway)."

The authors concluded sadly, "Despite the importance of this study, the investigators fear that people will continue to handle, fondle and jingle in their pockets—money."

As a panacea they suggested, "In order to further this research we will accept and examine any money sent to us. If it is found to be contaminated, we have facilities for its safe disposal."

The authors are Drs. Berel L. Abrams and Norton G. Waterman from the Department of Surgery, University of Louisville School of Medicine, Health Sciences Center, Louisville.


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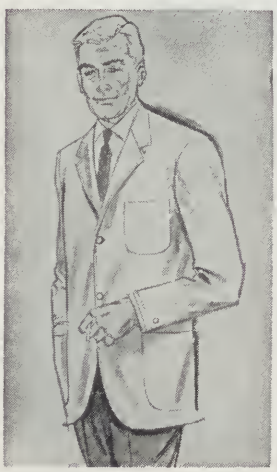
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## Traffic Accidents Continue

More than 55,200 men, women and children were killed in traffic accidents during 1970. However, experts see a glimmer of hope in this statistic.

In 1969 America's highway death toll was 56,500.

Much of the reduction in highway deaths, according to a survey by The Travelers Insurance Companies, may be attributed to safety features which have been installed in new vehicles since 1966. In addition, there may be a growing awareness by drivers of the need for safer driving.

The firm also notes that excessive speed was a major factor in more than 39% of the traffic deaths in 1970. Nearly half of the auto fatalities occurred during weekends during hours of darkness.

Though the number of deaths was down, the number of injuries from vehicular accidents was up. In 1969, some 4,700,000 persons were injured on highways in the United States. In 1970, the figure jumped to 5,100,000.

Another fact, one that has not changed much in several years, is that drivers under 25 years of age were involved in more than one third of all accidents, fatal and nonfatal. Yet this group represents a 15.7% increase over 1969.

Roger C. Wilkins, chairman of the board of The Travelers, suggests that even with safer cars and highways, "it will be our acceptance of these safer automobiles, our continuing pressure on appropriate authorities, and our acknowledgment of individual responsibility that will insure that we reach our goal of fewer and fewer accidents on our streets and highways."

## Hospital Costs Continue to Rise

The cost of providing care for one hospital patient for one day in 1970 was $81.01, the American Hospital Association reports. This represents a $15.7% increase over 1969.

Reports from the nation's 5,859 community hospitals showed total expenses at a new high of $19.6 billion. In 1969, the expenses totaled $16.6 billion.

Hospitals are feeling the inflated state of the national economy, according to Edwin L. Crosby, MD, executive president of AHA.

"The inflationary spiral of the nation's economy has played a large part in the rise of hospital costs," said Dr. Crosby. "Everything hospitals buy costs more than it did a year ago. And wages and salaries continue to increase."

Payroll expense in hospitals continued an upward trend that started in 1961. Community hospitals reported $11.4 billion paid in wages and salaries in 1970, a 16.4% increase over the $9.8 billion figure in 1969.

The 7,123 hospitals registered by AHA reported a total of 2,537,000 employees. The community hospital category listed 1,929,000 employees for a new high of 292 employees per 100 patients.

The 1970 occupancy rate for community hospitals showed a small drop from 78.8% in 1969 to 78% in 1970. Average length of stay decreased one tenth of a day from 8.3 to 8.2 days.

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More than 1,702,000 Americans over the age of 35 have glaucoma and half of them do not know it, warns the National Society for the Prevention of Blindness. Glaucoma, the "sneak thief of sight", may result in blindness unless detected early and treated continuously.

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American Radio Tel. Sv. ... 94

Arch Laboratories ... 82

Arundel Fed. Savings & Loan Assoc. ... 82

Baltimore Nurses Exchange ... 45

Beecham-Massengill Pharm. ... 33

Bristol Labs ... 81

Burroughs Welcome Co. ... 23, 53

Capital Savings & Loan Association ... 96

Oscar Caplan & Sons ... 12

Connecticut Mutual Life Insurance Co. ... 80

Dow Chemical Co. ... 49

Dulaney Towson Nursing & Convalescent Home ... 32

Embassy Dairy ... 94

Franklin Uniform Co. ... 97

Friends of Nursing ... 63

Geigy Pharmaceuticals ... 1

Herget & Co. ... 45

Lederle Laboratories ... 35-38

Eli Lilly & Co., Inc. ... 56

Mead Johnson & Co. ... 22

Med-Chi Directory ... 63

Med-Chi Insurance Trust ... 34

Med-Chi Retirement Plan ... 98

Pharmaceutical Mfrs. Assoc. ... 77-79

Wm. P. Poythress Co., Inc. ... 39-40

Public Service Vehicle Equipment Leasing ... 42

Geo. Radebaugh & Sons ... 15

Read's Drug Stores ... 12

Roche Laboratories ... Cover 4, 6-7, 33-34, 42-43, 90-91

Manuel Schwartz Hearing Rehabilitation 96

G. D. Searle Co. ... 50-51

Security Business Services, Inc. ... 15

Special Diet Shop ... 21

Sterling Lighting Co. ... 93

Stuart Pharmaceuticals ... 52, 54-55

Therapeutic Appliances ... 12

Tio Pepe Restaurant ... 94

Towson Valley Motors ... Cover 3

Upjohn Co. ... 24-26, 28-29

USV Pharm. Corp. ... 89

Winthrop Labs. ... 2-4

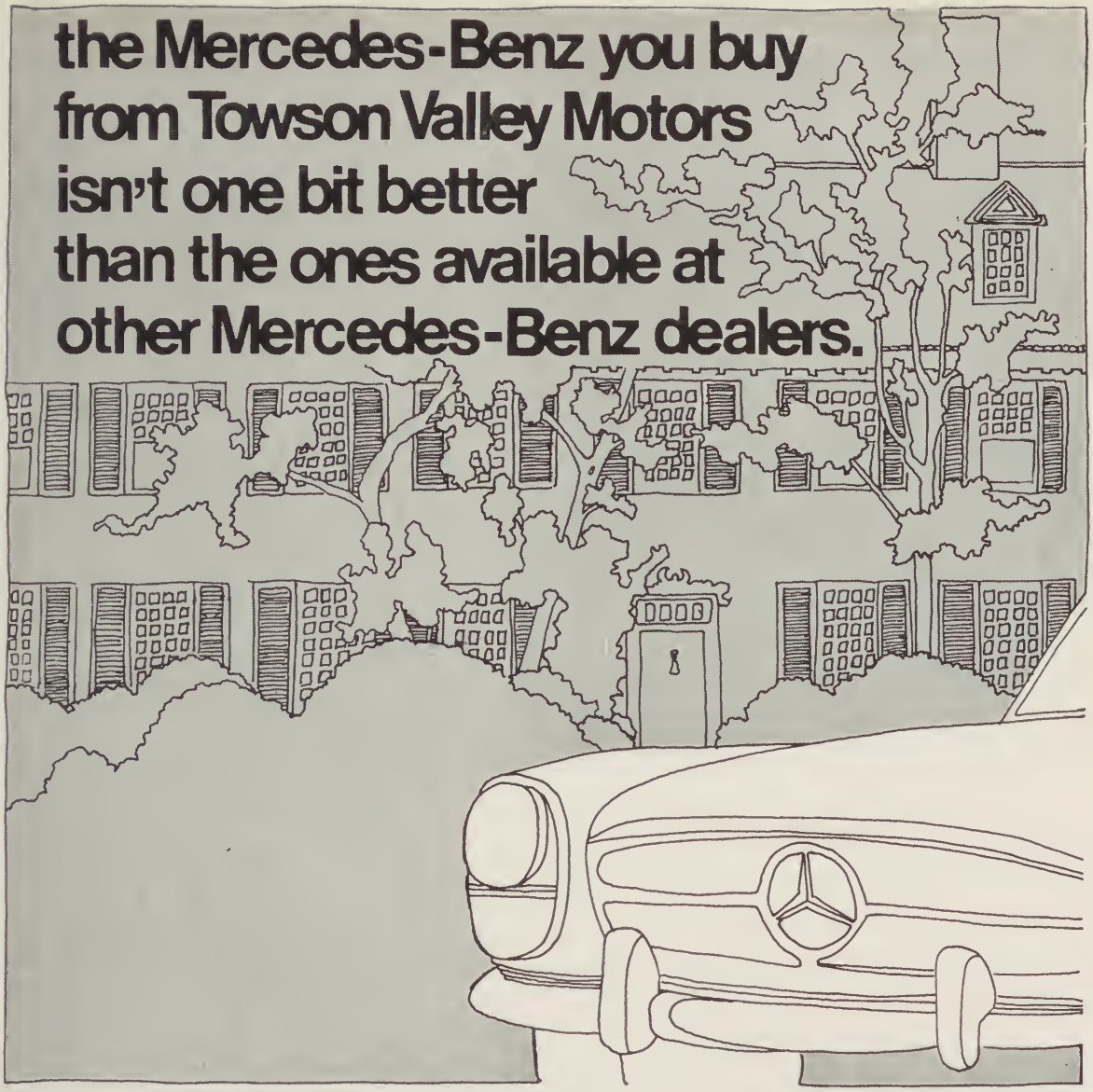
Warner-Chilcott Labs. ... 82-83

D. Stuart Webb Advertising Services, Inc. 93

White Rice Inn ... 94

Vera Woods Personnel Service ... 16

Zimmermann's Shoes ... 12




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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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VOLUME 21 JUNE 1972 NUMBER 6


**ARTICLES:**


**Depression—A Mood Disorder in Children and Adolescents** Harry Bakwin, MD ..... 55

**Psychological Factors Affecting Routine Medical Care —** Richard C. W. Hall, MD ..... 62

**Estimating Educational Casualty from the 1964 Rubella Epidemic in Maryland**—John A. Grant, MD, MPH; Allan M. Gittelsohn, PhD ..... 64


**DEPARTMENTS:**


**Woman's Auxiliary — Mrs. Kolkin Elected President** ..... 16

**Maryland Medical Political Action Committee — Congressman Roy Speaks on HMOs** ..... 17

**Your Medical Faculty at Work** — John Sargeant ..... 18

**Heart Page — Pitfalls of the Electrocardiogram —** Chris Papadopoulos, MD ..... 32

**Maryland State Department of Health and Mental Hygiene — Mentally Retarded: No Longer Society's Forgotten Children —** Robert E. DeHaven ..... 42

**Baltimore City Health Department — Accidental Poisoning; TB Study** ..... 44

**Rehabilitation Medicine — Evaluation and Management of Lumbar Disc Disease** — Ronald L. Paul, MD; John E. Gessner, MD ..... 76

**Alcoholism Section — Project REHAB: A Progress Report —** Miss Shirley E. Cooke ..... 82

**Library — It's Your Library; New Accessions** ..... 93



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**MISCELLANY:**


Doctors Take Note 5

Doctors in the News 8

Medical News Briefs 9

Director's Newsletter 13

Book Reviews 20

American Association of Medical Assistants 21

Hospital Salute 27

Semiannual Meeting news 34

Drug Advertising, Labeling 45

Open Forum 87

Component Societies 97

Classified Advertising 99

Advertising Index 100



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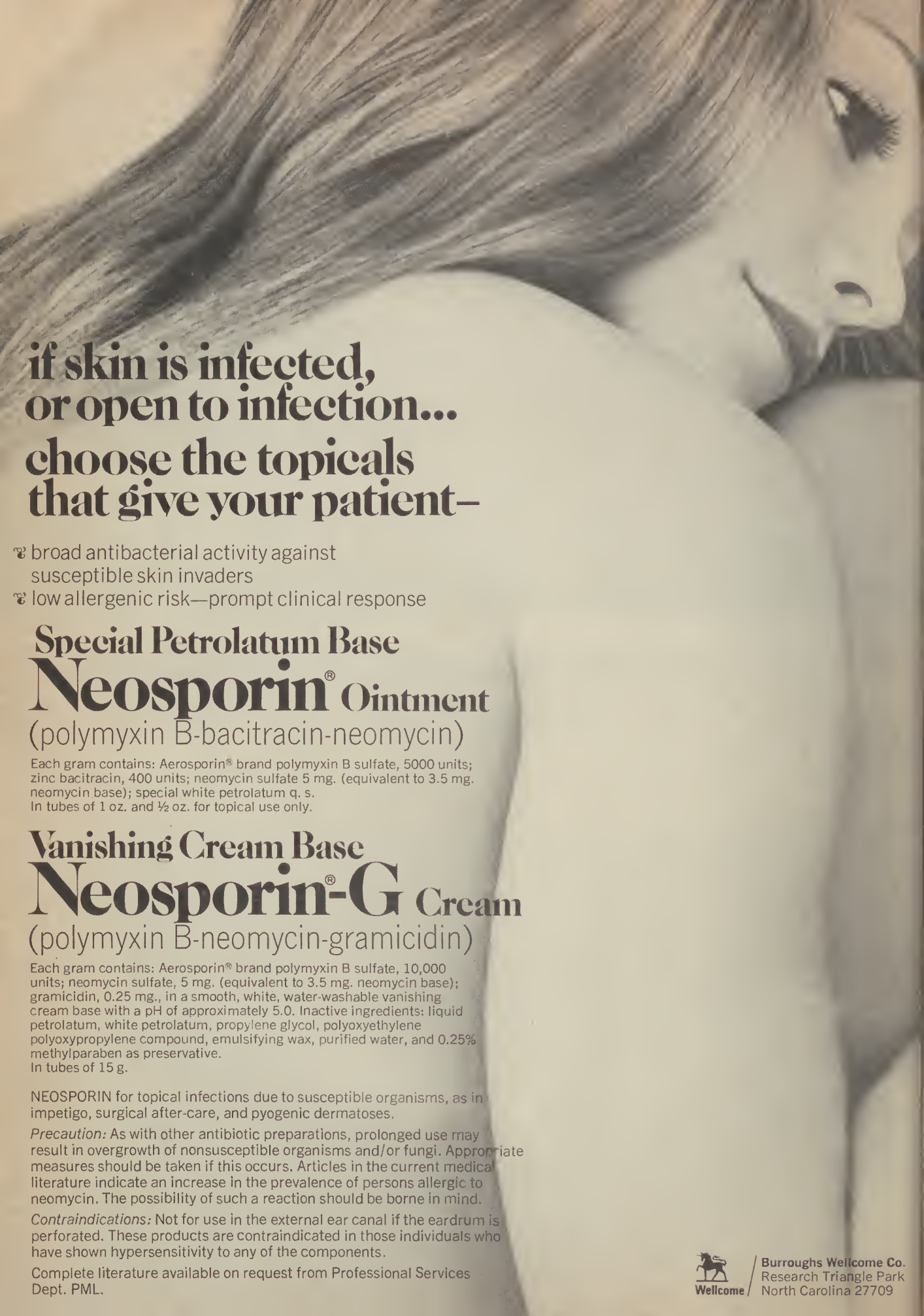
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*Warnings:* Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
*Precautions:* The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
*Adverse Reactions:* This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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*For complete details, including dosage, please see full prescribing information.*

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NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

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*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

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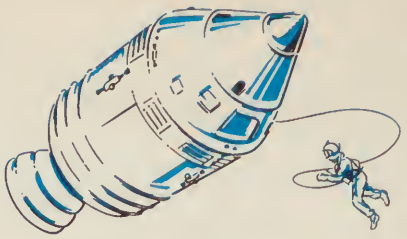
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*Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.*

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*A clinical supply will be sent to physicians and hospitals on request.*

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# Doctors take note...

## MARYLAND AREA MEETINGS

Jun 12-16 **Advanced Psychiatry for the Internist.** Sinai Hosp of Baltimore & Baltimore Dist of Columbia Inst for Psychoanalysis. Contact: ACP, 4200 Pine St, Phila Pa 19104.

Jun 23-25 **Weekend With Physicians,** St. Johns College, Annapolis. Sponsor: Md Heart Assoc. Contact: Heart Assoc of Md, 201 N Charles St, Suite 905, Baltimore Md 21201.

Aug 1-3 **US Civil Service Comm** Seminar on ADP in Med for Admin Personnel, Washington. Contact: ADP Mgt Trng Cen, US Civil Ser Comm, Washington DC 20415. Phone (202) 632-5650.

Aug 26-27 **American College of Surgeons, Maryland Chapter,** Sheraton Motor Inn, Fredericksburg Va. Contact: Elliott R Fishel MD, 338 W Pratt St, Baltimore Md 21210.

Aug 27 - Sep 2 **Joint International Transfusion Congress,** Washington. Sponsors: Amer Assoc of Blood Banks & International Society of Blood Transfusion. Contact: Transfusion Congress, AABB, Suite 401, 915 19th St, Washington DC 20006.

## MISCELLANEOUS MEETINGS

Jun 18-22 **AMA 121st Anl Conv.** San Francisco. 7 Postgrad crs: 1) Acute Respiratory Failure 2) Anorectal Disease 3) Antibiotics 4) Common Dermatoses 5) Experiential Learning 6) Hand Surgery 7) Liver Disease. $25 regis fee. 4-hr cr. Contact: Dept of Continuing Med Educ, AMA, 535 N Dearborn St, Chicago Ill 60610.

Jul 16-27 **Summer Program in Human Sexuality,** Indiana Univ. Regis $325 ends June 24. Contact: Summer Program, inst for Sex Research, Indiana Univ, Bloomington Ind 47401.

Jun 22-24 **Natl Conf on Human Values & Cancer.** Atlanta. Sponsor: American Cancer Society. Contact: Wm M Markel MD, Natl Conf on Human Values & Cancer, Amer Can Soc, 219 E 42nd St, New York NY 10017. No regis fee. Preregis required.

Jul 16-19 **Amer Assoc for Clinical Immunology & Allergy,** Seattle Wash. Anl mtg 16. Instructional sessions 17-19 in preparation for Conjoint Board in Allergy certification exams. Contact: AACI&A, PO Box 912 DTS, Omaha Neb 68101.

Jul 22-28 **Natl Assoc Underwater Instructors,** Honolulu. Spec crs to qualify drs in diving med. Contact: NAUI Hq, 22809 Barton Rd, Grand Terrace Calif 92324.

Jul 24-28 **1st Natl Workshop in Biomedical Electricity Electronics & Instrumentation,** Univ of Missouri-St. Louis. Contact: Dwight Hafeli, UMSL Extension Div, 8001 Natural Bridge Rd, St. Louis Mo 63121, phone (314) 453-5961.

Jul 24-28 **Physical Aspects of Nuclear Med,** Cambridge Mass. Sponsor: Mass Inst of Tech (MIT), Tuition $350, no acad cr. Contact: Bursars Office, MIT, Summer Session Office, Rm E19-356, Cambridge Mass 02139.

Jul 27-29 **10th International Conf on Extra-Corporeal Technology.** Waldorf-Astoria, New York. Contact: E C Berger, American Society of Extra-Corporeal Technology, 287 E 6th St, St Paul Minn 55101.

Aug 7-10 **American Health Congress-72,** Chicago. Sponsors: Amer Hosp Assoc, Catholic Hosp Assoc, Amer Nursing Home Assoc, Health Industries Assoc. Contact: Amer Health Congress, 840 N Lake Shore Dr, Chicago Ill 60611.

Sep 5-9 **XII Congress of Internal Med, Boston.** Sponsor: International Society of Internal Med. Contact: Thos A Warthin MD, Gen Chmn, XII International Congress of Internal Med, 4200 Pine St, Philadelphia Pa 19104.

Sep 11-12 **32nd Anl AMA Congress on Occupational Health, Chicago.** Contact: H F Howe MD, AMA, 535 N Dearborn St, Chicago Ill 60610.

Sep 12-15 **3rd Conf on Computer Applications in Radiology,** Med Cen of Univ of Missouri at Columbia. Fee $80. Contact: J L Mowrer, Conf Section, Continuing Med Educ, M-175 Med Cen, Columbia Mo 65201.



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Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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# (diazepam)

## To help you manage excessive psychic tension

# Doctors in the News

A group of 283 physicians, including 11 Marylanders, who have met the high standards of the American College of Physicians (ACP) has been granted Fellowship in the 56-year-old international medical specialty society.

The College dedicates itself to upgrading medical care, teaching, and research through stringent standards of membership and programs of continuing education.

The Maryland specialists in internal medicine or related specialties included in the new Fellows are:

**John G. Banwell,** MD; **Belur S. Bhagavan,** MD; **Joseph R. Bianchine,** MD; **Tapan A. Hazra,** MD; **Peter C. Luchsinger,** MD; and **Gordon M. Mullins,** MD; all are from Baltimore;

**Ronald B. Herberman,** MD; and **Harry R. Kimball,** MD, Bethesda;

**H. Thomas Foley,** MD, Cheverly;

**Col Robert J. T. Joy,** MC USA, Chevy Chase; and

**Elliott Perlin,** MD, Silver Spring.

These new Fellows have earned this distinction through certification by their specialty boards, presentation of published material, evidence of scientific accomplishments, and academic or hospital affiliations.

●

**Aris T. Allen,** MD, Annapolis, member of the Maryland House of Delegates from District 6-C, Anne Arundel County, has been appointed to the Advisory Council on Urban Transportation by John A. Volpe, US secretary of transportation.

●

**Moses Fraiman,** MD, has been elected president of the medical staff and chairman of the medical executive committee of Baltimore's Lutheran Hospital.

Dr. Fraiman has been associated with surgical education at Lutheran since 1963 and will now serve as director of Surgical Services.

A 1954 graduate of the Medical School of San Marcos University, Lima, Peru, Dr. Fraiman interned in surgery at Sinai Hospital (Baltimore) and was assistant resident in surgery at Lutheran from 1957 to 1961.

He attended the Lahey Clinic in Boston in 1961 and has been in the private practice of surgery in Baltimore since 1963.

●

**William R. Stecher,** MD, Silver Spring, has been honored for his outstanding work in medicine and for his contribution to Radiology by being named as Fellow in the American College of Radiology.

●

At a recent meeting of the Washington DC Metropolitan Area Chapter of the American College of Radiology, the following Marylanders were elected: **Albert Miele,** MD, Bethesda, president; and **Albert Zelna,** MD, Silver Spring secretary-treasurer.

CENTURY CLUB—The Board of Health of Baltimore County was photographed on the historic occasion of its 100th meeting recently at Department of Health headquarters in Towson. The Board was created under a bill enacted by the Baltimore County Council in Feb 1963. Its seven members are appointed by the County Executive and serve for terms of three years. The County Health Officer serves as secretary but has no vote. From the left: Hector DiNardo, MD, member; Henry Schilpp, member; Donald J. Roop, MD, Baltimore County Health Officer, secretary; Leonard P. Berger, MD, chairman; Margaret Sherrard, MD, Baltimore County Deputy Health Officer; Melvin Davis, MD, member; and Robert Gibson, MD, member. Absentees: Stephen K. Padussis, MD, vice chairman; and Milton Brownstein.



# Medical News Briefs

## St. Agnes Hospital Visitor Pass System

Baltimore's St. Agnes Hospital adopted a visitor pass system in April after pondering its use for nearly a year.

Questionnaires given patients revealed many were annoyed by too many visitors and many asked to limit their visitors to members of the immediate family. The new system will provide closer regulation of limiting visitors to two per patient.

Their administrator expressed the hope that everyone understands the situation confronting them and that they will adhere to the new visitor's policy.

## Ovarian Carcinoma

Cooperation of physicians is requested in the referral of patients for a controlled clinical trial of the treatment of advanced ovarian carcinoma being conducted by the National Cancer Institute's Solid Tumor Service at the Clinical Center, National Institutes of Health, Bethesda, Md.

Previously untreated patients with serous or undifferentiated ovarian carcinomas Stage III or IV (International Classification) are needed for this study.

Of particular interest are patients with ascites, since pretreatment assessment of aspects of the cell cycle estimations of the effectiveness of each dose of administered drug and other studies are performed on available tumor tissue prior to therapy.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission may write Admitting Office, National Cancer Institute, Clinical Center, Room 4-B-17, Bethesda, Md 20014; or phone Vincent T. DeVita, MD, or Robert C. Young, MD, 301-496-2031.

## Heroin's Use Rejected

Any plan that would provide free heroin to addicts instead of continuing with methadone maintenance therapy has been denounced by Neil Solomon, MD, Maryland's health and mental hygiene secretary.

"Although such a program has been tried in other countries, notably England," he continued, "the attempt in that country has proved to be a failure, and an overwhelming number of physicians are now prescribing methadone there."

According to Stuart L. Nightingale, MD, medical director of the Maryland Drug Abuse Administration, there is ample clinical reasoning behind rejection of giving heroin to addicts.

"Heroin," Dr. Nightingale said, "has a short duration of action and cannot be well absorbed orally. Therefore it must be injected several times each day.

"On the other hand methadone, as used in our programs, is taken orally only once a day on maintenance. It produces no euphoria, and allows the addict to remain with his family in most cases, earn a living, and regain his self-respect while being counseled in the direction of reduction of his dependence on drugs.

"For many reasons," Dr. Nightingale said, "we reject any plan to provide heroin to addicts as a dangerous step in the wrong direction. Our maintenance and reduction programs employing methadone are at this time far and away the best answer we have. Although we continue to look to researchers for other methods of dealing with addicts, methadone programs are now our most successful approach."





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## Lung Carcinoma

Cooperation of physicians is requested in the referral of patients with carcinoma of the lung for clinical study and treatment by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Md.

All previously untreated patients with a tissue or unequivocal cytologic diagnosis of bronchogenic carcinoma, who are unresectable because of local extension only, or who refuse surgery, will be considered. Patients who have had an attempted partial resection, or patients with serious medical complications contraindicating surgery are not acceptable.

Upon completion of treatment, patients will be returned to the care of the referring physician, who will immediately receive a summary of the findings.

Physicians interested in having their patients considered for admission to this study may write or phone Kent B. Lamoureux, MD, Clinical Center, Room B3B-38, National Institutes of Health, Bethesda, Md 20014. Phone 301-496-5457.

## Anti-Chickenpox Serum Bank Aids Ill Children

A new program to establish an anti-chickenpox serum bank was announced recently by Maryland health and mental hygiene secretary, Neil Solomon, MD. He said it will be a model after which similar programs in other states will be patterned.

"Chickenpox can be deadly for children who have to take certain drugs to combat arthritis, kidney disease, leukemia and other forms of cancer," the secretary said. "These drugs produce a side effect which lowers the body's natural defenses against infection," he continued, "and under these conditions, exposure to another child who has chickenpox can be very dangerous for these children."

Dr. Solomon said the project, which is being jointly sponsored by several other health agencies, is aimed at providing a stockpile of the serum to be used when children with chronic diseases are exposed to chickenpox.

According to John D. Stafford, MD, acting chief of the Division of Communicable Diseases, the risk of complications following chickenpox exposure can be reduced by giving these children serum obtained from the blood of adults who have recently had the disease, or a similar disease known as shingles.

On a routine basis, all adults who have either chickenpox or shingles will be contacted and asked to donate some of their blood for which they will be paid $25. The blood will then be processed to extract the serum, called zoster immune plasma (ZIP), which will be frozen and put into the bank. When high risk, seriously ill children are exposed to chickenpox, the ZIP will be administered if it appears medically advisable.

Any adult who has recently had chickenpox or shingles and wishes to donate blood, should contact his family or clinic physician, who will notify Dr. Stafford.

## Clinical Center Study

Cooperation of physicians is requested in the referral of patients with acute viral hepatitis, Australia antigen positive, for studies being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, Bethesda, Md.

Needed are patients for inpatient studies of immunologic reactivity. Preference will be given to those individuals who are in the early stages of the disease. Patients who are addicted to drugs, who have chronic hepatitis, or who have any other serious chronic disease will not be considered. Patients who have severe hepatitis with impending coma or abnormal prothrombin time would not be good candidates.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to this study may write or phone the Clinical Center, NIH, Bethesda, Md 20014 contacting Paul H. Plotz, MD, Room 9N-210, phone 301-496-1474, or Saul Agus, MD, phone 301-496-4201.

## DID YOU KNOW?

- Suicides cost the nation about $16 billion annually.
- This is based partly on the 22,000 suicides officially recorded in this country each year, and reflects wasted human potential and earning power.
- Suicide has become this nation's 11th most common cause of death.
- Current estimates are that there are about 10 attempts for each successful suicide, or about a quarter-of-a-million attempts each year.
- When alcohol is present either as a primary or secondary diagnosis, the suicide risk is markedly increased.
- Suicide rates for married persons on the whole are lower than those for single, widowed or divorced.
- Rates for divorced persons are three to five times the rates of married persons under 65.

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# executive director's newsletter

June 1972

RECENT COMMITTEE ACTIONS

Recent actions of Faculty committees include the following decisions of interest to physicians throughout the state:

The Mediation Committee has ruled it is unethical for a physician to release information to a credit reporting agency regarding the physical condition of the patient. This decision was reached in response to requests for medical data by credit reporting organizations, acting on behalf of insurance companies. The decision dealt with the release of medical reports to non-medical persons.

In other actions, it has been ruled that a physician may charge interest on accounts that are in litigation because of liability, when deferment of payment is made to enable settlement to be reached. The opportunity must be given the patient to make payment without such interest payments if paid at the time the account is due. Full disclosure of interest charges should be made in accordance with federal credit regulations.

Action recently taken also approves of an assignment form to enable physicians to be adequately protected when cases are in litigation. Such assignment form has been approved by the Faculty's Medicolegal Committee for use. It, in essence, commits the patient through his attorney to payment of the physician's bill for treatment from settlement proceeds; and also makes it clear the physician's bill is due regardless of the outcome of any litigation.

The Program and Arrangements Committee is considering a location outside of the Continental United States for the 1973 Semiannual Session. The 1972 Semiannual meeting is already scheduled for Ocean City, Md.

RESOLUTIONS FOR SEMIANNUAL SESSION

Resolutions to be considered at the Faculty's Semiannual Session in Ocean City, Md., must be in the Faculty office NO LATER THAN FRIDAY, JULY 21, 1972. This is in accordance with Faculty Bylaws that require such resolutions to be received no later than eight weeks prior to the date of such meeting.

BANK CARDS

The Mediation Committee has also revised its policies with respect to the use of Bank Credit Cards by physicians. The new policy provides as follows:

(1) The physician should be satisfied as to the financial and professional integrity of the plan. The physician should insure that service charges are reasonable. The plan should be open to all physicians on the same terms and it should not exploit or capitalize on physicians' participation in the plan. The listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

(2) The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other devices indicating participation in the plan within the physician's office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation, visible outside the physician's office, are unacceptable.

(3) The use of a bank card in connection with the payment of larger fees - which might normally be paid to the physician in installments - is not to be encouraged. All members are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations "to render service to humanity, reward or financial gain being a subordinate consideration."

ANNUAL MEETING REGISTRATION

Registration at the 1972 Annual Meeting totalled 1,864, the highest ever recorded.



Executive Director

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# SILVER SPRING WOMAN ELECTED AUXILIARY PRESIDENT

Mrs. Marvin L. Kolkin of Silver Spring was installed as President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland at the 23rd Annual Convention on May 4, 1972, held at the Baltimore Hilton Hotel.

Caryl Kolkin was born and raised in New York; she was also educated there, having attended The Calhoun School, Adelphi University, and City College of New York. She married Dr. Kolkin at the conclusion of his internship 24 years ago. For the past 17 years, Dr. Kolkin has been practicing thoracic and cardiovascular surgery in Montgomery County.

The Kolkins have three sons: Mitchell, a recent graduate, cum laude, of the University of Pennsylvania, having majored in history; Jon, in his final year of pre-med studies at Emory University, an accomplished clarinetist as well as a member of the Emory University's outstanding Glee Club and American Youth Symphony; and Seth, a sophomore at Sandy Spring Friends School, also interested in medicine, working as a regular volunteer at a local hospital, and also an accomplished musician. All three of



Mrs. Kolkin

the boys are avid sportsmen, having been active on school track, tennis, and soccer teams.

Caryl is a very involved mother who shares her husband's and sons' talents and hobbies. She, too, is a musician and often plays the piano to accompany her sons when they give clarinet performances. The family's favorite recreation is boating on the Chesapeake in their cabin cruiser, "Spare Rib." In fact, Dr. and Mrs. Kolkin traveled to the AMA Convention in Atlantic City last June in their boat. Caryl is happy in the domestic scene, too, enjoying and excelling in cooking and knitting. At the time she begins her many Auxiliary activities, she will be much involved in settling into a new home in a country atmosphere, in Ashton.

Caryl has served as president of the Greater Washington Chapter of the Women's Auxiliary to Phi Delta Epsilon Medical Fraternity, and also as president of the Woman's Auxiliary to the Montgomery County Medical Society. Her work in her husband's office has helped make her aware of the day-to-day situations and problems confronted by the private practitioner.

She believes firmly in the obligation to provide for and work toward the realization of obtaining the best possible health care for all Americans under the existing health care delivery system. She feels that Auxiliary activities can and should be geared to the attainment of that goal, and that Auxiliary members should stand ready to assist the component medical societies in whatever areas they feel the Auxiliary can be useful.

The Auxiliary is proud to have this bright, energetic, and dedicated woman at its helm.

# CONGRESSMAN ROY SPEAKS ON HMOs

Congressman William R. Roy, MD, of Kansas, speaking at the MMPAC Luncheon during the Annual Meeting, devoted the greater part of his talk to a discussion of HMOs and of the Health Maintenance Organization Act of which he is one of the sponsors.

Dr. Roy pinpointed three basic problems in the delivery of health care in the United States. They are: 1) the shortage and inappropriate nature of health care services, 2) the escalating costs of health care, and 3) the variable quality of health care.

He feels the shortage of health care is manifested in three separate areas. While the national average physician to population ratio is 150 to 100,000, there are inner-city and rural areas where the ratio falls as low as five physicians per 100,000 people. Accessibility is a further problem. Health services may be rendered inefficient because of poor transportation, language barriers, or inconvenient hours of operation. Finally, he cites the problem of continuity of health care. A single patient may be treated not as an individual, but rather as a multipilicity of health problems each unrelated to any previous or simultaneous health problems.

Dr. Roy blamed the escalating costs of health care on two factors. Most important is the limited supply of health services available which brings into play the traditional laws of supply and demand. Secondly, he mentioned the uncontrolled nature of the current health financing mechanism. The major purchasers of health care — indemnity insurance plans and the Federal government — have traditionally paid for services without exercising any cost review or control. Consequently, services and facilities are duplicated, and the introduction of new management and cost-saving techniques is delayed.

The quality of health care varies because there is no quality assessment process or peer review in most areas of the United States. As a result there is also no system to rectify shortcomings discovered by the process of quality assessment by such means as continuing education.

Rep. Roy stated that his HMO proposal would go far to solve these problems of American medicine.

An HMO as a health care delivery organization can assure the availability of care. It can insure adequate numbers of doctors and inpatient facilities for its members. An HMO can study utilization patterns and survey its members to determine deficiences in the accessibility of care. Continuity can be assured by providing defined interrelationships between the providers and the agencies and patients in the HMO system.

The legislation introduced by Congressman Roy would require that an HMO deliver comprehensive services and "demonstrate to the satisfaction of the Secretary, proof of ability to assure that comprehensive health care services are available to all its members promptly and appropriately." The continuity of patient care would be the responsibility of the HMO. In the same connection the HMO would be required in some way to involve its members in the policy-making role of the organization, not in the matter of quality of care, but in the areas of availability, accessibility, and continuity of care.

The HMO would alleviate the escalating costs of medical care because it would have a limited membership paying a specific sum to the provider. Fixed income provides an HMO with an incentive to limit its expenses, analyze its operation, and implement economies and efficiencies. Records of costs must be kept, and a full accounting made to the Secretary and the members at least annually. Dr. Roy feels that while a single HMO may contribute only marginally to alleviate the inflation in health care, a national HMO strategy may serve such a purpose very well.

To insure a high quality of care the proposed legislation requires an HMO to have organizational arrangements for an ongoing quality assurance program. Currently this would mean mostly peer review; however, when more sophisticated monitoring techniques are perfected the HMO would be expected to adopt them. A program of continuing education would be encouraged. Disclosure provisions will allow for a comparison between different HMOs as to the effect of their services on the health of members. Dr. Roy concluded:

"The resolution of the health crisis will require major improvement in many areas: first, manpower; second, facilities; third, biomedical knowledge; fourth, financing; and fifth, organization. This HMO proposal is important, and may, in fact, even be the *sine qua non* of the resolution of the health crisis. For without a reorganization of our health care delivery system, manpower will continue to be maldistributed and inappropriately employed, facilities will remain poorly located and inefficiently managed, knowledge will fail to affect those who need it most, and additional financing will be inflationary."

MRS. FRANCIS C. MAYLE, Editor
Maryland Medical Political Action Committee

# your medical faculty at work

**by John Sargeant,**
**Executive Director**

**The Executive Committee met on Thursday, April 13, 1972 and took the following actions:**

1. Approved publication by a special flyer or mailing to the membership advising that services are available to physicians who may be afflicted with the disease of alcoholism.
2. Agreed to oppose any attempt by the legislature to transfer the health licensure boards from the Department of Health and Mental Hygiene to the Department of Licensing and Regulation.
3. Approved previous policy with respect to collection of statistical data involving salaries and fringe benefits of full-time physicians; as well as stated its intention to a) interview on a personal basis those full-time physicians who are currently nonmembers of the Faculty to determine the reasons for such nonmembership; b) inform Faculty delegates to the AMA House of Delegates that it supports the concept that the AMA develop a section or make efforts to provide specific benefits for full-time salaried physicians who do not benefit from many of the other AMA activities; and c) conduct a survey of the present members who are on a full-time salaried basis for the purpose of soliciting information as to their needs and what the Faculty can do to assist in fulfilling these needs.
4. Agreed to invite a representative of the AMA Board of Trustees to speak to the House of Delegates at the Faculty's Annual Session regarding the AMA and what activities it currently is engaged in; and suggested that one or more of the Faculty's delegates to the AMA might also wish to comment on this.
5. Endorsed a research application grant to be submitted by the Department of Preventive Medicine, University of Maryland School of Medicine, dealing with the Multiple Risk Factor Intervention Trial for the Prevention of Coronary Heart Disease.
6. Declined to sell at this time the 750 shares of the Elkton Bank and Trust Company currently owned by the Faculty.
7. Increased the mileage allowance to 15c per mile, inasmuch as this is the figure determined by IRS in this regard.
8. Declined to approve legal defense for a member who requested it because of an oversight in his office, resulting in late payment of 1972 dues. It was pointed out that it would be a violation of Faculty Bylaws to accede to this request.
9. Approved payment of legal fees in connection with a case defended on behalf of a physician member, subject to approval by legal counsel.
10. Approved inclusion of all component medical societies in the Faculty's libel and slander insurance policy at no cost to them. It is to be emphasized this does not cover officers of the components, but only the society itself.
11. Declined to participate in a Sustaining Membership of the Maryland Public Health Association because of divergent policy views of the parent organization of this group and the Faculty.
12. Submitted names for possible appointment to the Advisory Council on Hospital Licensing.
13. Submitted for reappointment the name of Donald T. Lewers, MD, for the Maryland Commission on Kidney Disease.
14. Declined to erect a sign outside of the Faculty building, indicating the offices of the Baltimore City Medical Society are located therein. This was done on the basis that such a sign would have to be posted for all other groups located in the building, and that the vestibule sign adequately performed this function.
15. Referred to the Public Relations Committee the question of an educational program for members on National Health Insurance.

16. Concurred in a communication from member William H. Mosberg, MD, and stated that the Faculty is taking steps to accomplish the objective of protesting some of the inaccurate statements dealing with Medicare, Medicaid, and the "crisis in health care."

17. Agreed to take no action on a request from an individual delegate to introduce a resolution on his behalf at the Annual Session.

18. Heard a report that a fund cut has been experienced by the Maryland Regional Medical Program.

19. Heard that the date of May 4, 1972, has been set for the trial of the Faculty's suit against use of the term "Chiropractic Physician."

20. Heard that a Task Force of the Comprehensive Health Planning Agency had been named to "produce definitions, recommendations, and guidelines for the further development of ambulatory health care facilities in Maryland" and that such group had no private physician representation on it. A protest has been registered with the CHPA in this regard.

21. Heard that the AMA is planning a membership campaign in connection with non-AMA members.

22. Declined to take action in connection with a request for Affiliate Membership in the American Association for Comprehensive Planning at a cost of $200 per year.

23. Agreed to accept fiduciary responsibility for the Albert E. Goldstein, MD, Memorial Lecture Fund.

24. Approved the 1972 Semiannual meeting schedule, as well as 1975 Annual Meeting dates.

25. Approved expenditure of up to $500 if needed for the Annual Medicine in Sports Seminar.

26. Agreed to submit names to the office of U.S. Senator Charles Mathias in connection with possible appointment to HEW Advisory Committees. The names are for appointments in the fields of Pediatrics, Obstetrics, Gynecology, and Ophthalmology.

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**RESPIRATORY PHYSIOLOGY, by N. Balfour Slonim, MD, and Lyle H. Hamilton, PhD, second edition, the C. V. Mosby Company, St. Louis, 1971.**

The material contained in this publication is the product of experience gained in both teaching physiology and practicing medicine. Primarily designed for the medical student, it should prove useful as well to the physician, physiologist, and environmental scientist. Some sections will appeal to paramedical personnel such as nurses, inhalation therapists, and others. An attempt has been made to identify and propound the pressing problems of the field and to distinguish established fact from unproved speculation. This it does well.

**EMERGENCY SERVICES, The Hospital Emergency Department in an Emergency Care System, published by the American Hospital Association, 1972.**

This soft cover booklet enunciates general principles for appraising and planning the various elements of a hospital emergency department and for establishing suitable policies and procedures therein. It also discusses issues and problems relating to the changing scene in this area. In this day and age when criticism is being directed against the entire health care system, this manual provides an answer for some of the problems facing us all.

**A DECADE OF PROGRESS THE UNITED STATES ARMY MEDICAL DEPARTMENT, 1959-1969, by Colonel William S. Mullins, MSC, USA, Office of the Surgeon General, Department of the Army, Washington, DC, 1972.**

Among the dramatic examples of the revolutionary aspects of current combat medical practice during this period was employment of the helicopter for evacuation of wounded soldiers, saving precious time and allowing medical personnel the opportunity to apply their skills with much improved efficiency. While this book is not dedicated to this particular aspect of medical evacuation, it does provide insight into the nature and scope of the Army's medical services during the period of the Vietnam War.

**HANDBOOK FOR THE ORTHOPAEDIC ASSISTANT, by F. Richard Schneider, MD, The C.V. Mosby Company, St. Louis, 1972.**

This publication is perhaps the first of many that will be issued dealing with help for the assistant to a specialist (one who is trained to assist the physician and to whom certain duties may be delegated). The preface to this edition states, ". . . for this health personnel to be effective, he must be familiar with relevant didactic material and perform technical skills with expertise." It is obvious this publication will be of interest and considerable help to persons other than those who hold the formal designation of Orthopedic Assistant. Many Orthopedists train their office help to assist them in performing certain technical aspects of their practice and they would certainly benefit from reading this book. We can highly recommend its purchase by Orthopedists or others who perform this type of work. It covers a relevantly new area of concern and an area that will be expanding as paramedical personnel move in to fill gaps now existing in the delivery of medical care.

**THE CHINESE ART OF HEALING, by Stephen Palos, Bantam Books, New York City, 1972.**

This paperbook edition has been published at a most appropriate time. What with intense interest on the part of the public in acupuncture, triggered by James Reston's treatment in China; and by the President's recent visit there, this promises to be a best seller. For the person who wishes to know more about the ancient Chinese methods of healing, including acupuncture, it is well worth purchasing. The book traces the history of Chinese medicine and the struggle between those who wished to follow the more scientific principles and the traditionalists. It makes a good case for some of the ancient Chinese treatments, including acupuncture. But to the person who has a strictly scientific outlook on the healing arts, it will leave much to be desired.

**THE CARE OF MINOR HAND INJURIES, by Adrian E. Flatt, MD, The C.V. Mosby Company, St. Louis, 1972.**

This is the second edition of this book, the first having been published in 1959. It is divided into two sections, the first stressing the important principles, a knowledge of which is fundamental in good care of the injured hand; and the second dealing with a discussion of the treatment of the various types of injuries. All chapters have been extensively rewritten and 39 additional illustrations have been used to stress the appropriate principles of care. This is a book that one can term as "excellent," and this we do.

# American Association of Medical Assistants

## Baltimore City Chapter

Mr. Steven Sabo, Bureau of Narcotics, spoke at the February meeting on the subject of "Drug Abuse." His presentation was accompanied by an exhibition of narcotics and related paraphernalia. He discussed many phases of the narcotic problem of which the public is unaware.

Richard Humphrey, MD, at the March meeting, spoke on the Maryland Regional Cancer Research Center and the need for expansion. He explored the need for cancer research with startling statistics on the rise of cancer, especially in cancer of the lung.

Dr. Humphrey is assistant professor in Medicine and assistant professor in Microbiology at University Hospital, assistant physician and physician in The Johns Hopkins Outpatient Department, and assistant chief physician, Oncology and visiting physician, Baltimore City Hospitals.

## Anne Arundel Chapter

A State Seminar was held in Annapolis on March 19 at the Anne Arundel General Hospital. Introductions were made by Mrs. Linda Womack, chapter president.

"Are You Well Groomed in Medical Ethics?" was the seminar theme.

"Case in Point" was shown by the Wyeth Laboratories' Charles Bowie. This is a medical-legal film of actual cases tried in court. It is beneficial to both the doctor and the medical assistant in helping to avoid malpractice suits.

"Ethics for a Medical Assistant" was presented by H. Dabney Kerr, MD, radiotherapist at the Anne Arundel General Hospital.

Dr. Kerr is one of the outstanding men in the field of Radiotherapy. He is one of the very few men to receive two gold medals: one from the American College of Radiology, the other from the Radiological Society of North America. Early in his career, he practiced for seven years at Hope Hospital in China as a surgeon and later spent 25 years as professor and chief of Radiology at the University of Iowa School of Medicine. He presently practices at Memorial Hospital in Easton.

Mrs. Gloria Wood, registered records administrator, Anne Arundel General Hospital, discussed the "Medical-Legal Aspects of Medical Record Keeping." Mrs. Wood has past experience at Union Memorial Hospital in Baltimore, the Methodist Hospital of the Texas Medical Center in Houston, and Memorial Hospital in Sarasota, Fla. She received her master's degree from the University of Wisconsin.

A luncheon and fashion show concluded the meeting, attended by medical assistants from Baltimore, Cumberland, Washington, Virginia, West Virginia, and Annapolis.

The Anne Arundel Chapter of AAMA has concluded a series of courses on Anatomy & Physiology at the Anne Arundel General Hospital. The course began on October 28 and ended on May 11.

RITA COBRY, CMA
Publicity Chairman

●

There is no magic juice in the beefsteak to heal a black eye. For treating a black eye, the National Society for the Prevention of Blindness, advises cold compresses.





歡迎

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**Warnings:** When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

**Drug Dependence:** Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

**Usage In Pregnancy:** The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

**Usage In Children:** Not recommended for use in children under 12 years of age.

**Precautions:** In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

**Adverse Reactions: Central Nervous System:** When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

**Dosage and Administration:** The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

**Overdosage: Manifestations:** Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

**Management:** Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

**How Supplied:** Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

**Full information available on request.**

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# Pre-Sate®

## (chlorphentermine HCl)

## the trend is toward our kind of anorectic



**Not a controlled drug under the Comprehensive Drug Abuse Prevention and Control Act**

- low potential for abuse
- less CNS stimulation than with d-amphetamine or phenmetrazine

**Effective anorectic adjunct to your program of caloric restriction and diet re-education**

- weight loss comparable to d-amphetamine and phenmetrazine, superior to placebo
- convenient one-a-day dosage

-GP-21-B/W

**Pre-Sate®** (chlorphentermine HCl)...the increasingly practical appetite suppressant



# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains f pneumococci, streptococci, and taphylococci, including penicillin-esistant strains. Staphylococcal strains esistant to Lincocin (lincomycin ydrochloride, Upjohn) have been ecovered. Before initiating therapy, ulture and susceptibility studies should e performed. Lincocin has proved aluable in treating patients hyper-ensitive to penicillin or cephalosporins, ince Lincocin does not share ntigenicity with these compounds. lowever, hypersensitivity reactions ave been reported, some of these in atients known to be sensitive to enicillin.

**Well tolerated at infusion site:** Lincocin ntravenous infusions have not roduced local irritation or phlebitis, hen given as recommended. Lincocin s usually well tolerated in patients who re hypersensitive to other drugs. Nevertheless, Lincocin should be used autiously in patients with asthma or ignificant allergies.

n patients with impaired renal function, he recommended dose of Lincocin hould be reduced to 25—30% of he dose for patients with normal idney function. Its safety in regnant patients and in infants ess than one month of age has ot been established.

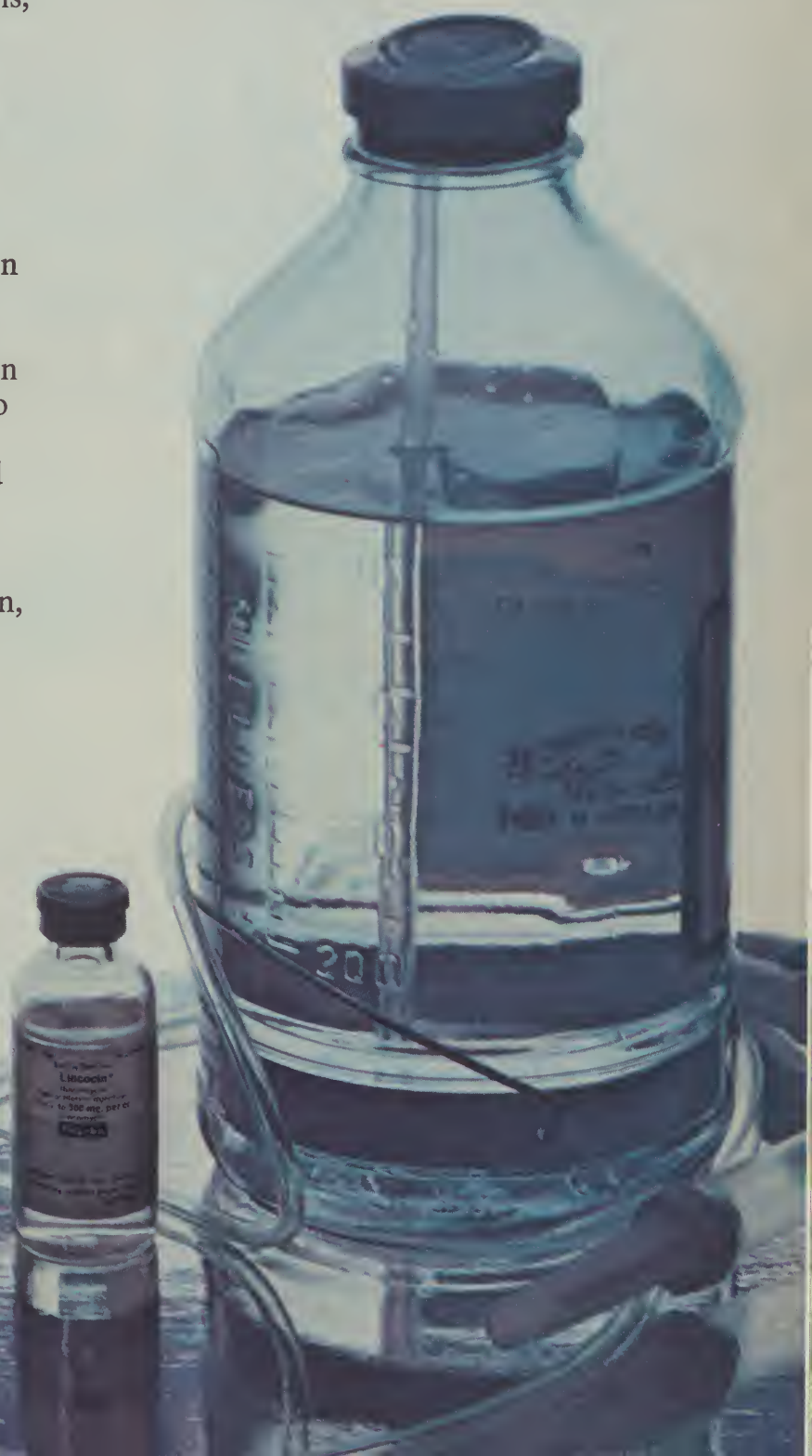
**Lincocin may be used with other ntimicrobial agents:** Since Lincocin s stable over a wide pH range, it is uitable for incorporation in ntravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.




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Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatmer *Skin and mucous membranes*—Skin rash urticaria, vaginitis, and rare instances of e foliative and vesiculobullous dermatitis ha been reported. *Liver*—Although no direct r lationship to liver dysfunction is establishe jaundice and abnormal liver function te (particularly serum transaminase) have be observed in a few instances. *Cardiovascul* —Instances of hypotension following pare teral administration have been reporte particularly after too rapid IV administr tion. Rare instances of cardiopulmonary a rest have been reported after too rapid I administration. If 4.0 grams or more admi istered IV, dilute in 500 ml of fluid a administer no faster than 100 ml per ho *Special senses*—Tinnitus and vertigo ha been reported occasionally. *Local reactio* —Excellent local tolerance demonstrated intramuscularly administered Lincoc (lincomycin hydrochloride). Reports of pa following injection have been infreque Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distill water or normal saline has produced l local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 m* Capsules—bottles of 24 and 100. *Steri Solution, 300 mg per ml*—2 and 10 ml via and 2 ml syringe. *Syrup, 250 mg per 5 m* —60 ml and pint bottles.

*For additional product information, const the package insert or see your Upjol representative.*

MED B-6-S (KZL-7) JA71-16

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Kalamazoo, Michigan 49001

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# THE GOOD SAMARITAN HOSPITAL

The Good Samaritan Hospital is a nonprofit special hospital made possible by the munificence of a Baltimore merchant philanthropist with a Horatio Alger background, Thomas O'Neill, who left $3.5 million at the time of his death in 1919 for a hospital in exactly the same manner as Johns Hopkins had done two generations earlier. In his will he named an independent, self-perpetuating Board of Trustees to govern the hospital. He gave them a few simple instructions among which were to build a hospital, utilizing only 40% of the corpus for the building; to promote health education; to carry on research in the hospital; and to provide the equivalent of 20 free beds.

Since he was a very devout Roman Catholic, he asked the Board to always name as its chairman the current Roman Catholic Bishop of Baltimore. He also asked the Board to see that an order of nuns (and he gave his preferences) be asked to nurse in the hospital. The trustees have followed his instructions faithfully, and the Daughters of Charity accepted the invitation to direct and operate the nursing activities in the hospital after the Sisters of Bon Secours withdrew.

The original $3.5 million grew over a period of years under wise and careful fiscal management and tax freedom to some $37 million. At the time the hospital was built in 1966 and 1967, 40% of the money was used to complete the buildings; 60% of the corpus remains as a permanent endowment.

The hospital is an integral part of The Johns Hopkins Medical Institutions, having been joined by an agreement of affiliation which was carefully worked out among the trustees of The Good Samaritan Hospital, The Johns Hopkins University, and The Johns Hopkins Hospital. The Hopkins was given the job of running the hospital, administratively and medically. The corporations remain separate although the trustee bodies are interlocking. Thus, The Good Samaritan Hospital is a teaching hospital for The Johns Hopkins Medical School. Programs carried out in the hospital are dovetailed so as to be complementary to programs that the Medical School carries out in The Hopkins Hospital and the Baltimore City Hospitals. All members of the staff at The Good Samaritan Hospital are either faculty members in the Hopkins Medical School and/or members of the staff of the Hopkins Hospital.

The chairmen of the respective clinical departments in the Medical School who serve as the directors of the clinical departments at the Hopkins Hospital also serve, in most instances, in The Good Samaritan Hospital in the same capacity, although some deputies have been named. This group forms the Medical Board of The Good Samaritan Hospital, the governing body for the medical staff under the trustees. (Three elected medical staff members are also included.)

When The Good Samaritan Hospital was being planned in the early mid-sixties, careful consultation by the trustees with the Maryland State Health Department, the Maryland State Planning Commission, the United States Public Health Service, and other appropriate governmental and professional groups resulted in plans for the hospital's being constructed so as to provide adequate care for patients with long-term illness, ie, provide total continuous care of patients with selected chronic diseases.

It must be understood what the term "long term illness hospital" means. In most people's minds the term connotes an "end of the road" custodial care institution or a "super nursing home." Neither of these concepts was envisioned by the planners. The trustees viewed the hospital as giving all levels of care (acute and intensive care, short-term and long-term inhospital care, and hospital-based home care) to individuals suffering from certain diseases which were permanent, which cause enduring disability, and for which specific comprehensive care programs might be designed. They selected diseases whose base was a tissue or cellular hypersensitivity such as arthritis, connective tissue diseases (lupus erythematosus), hay fever, asthma, asthmatic bronchitis and resultant obstructive pulmonary disease, and renal disease-particularly with transplantation in mind. Other diseases causing long-term illness such as vascular disease in the central, coronary, and peripheral circulations; endocrine diseases such as diabetes and Addison's disease; and neurological diseases of metabolic, genetic, and traumatic origins were also designated.

The trustees thus built and equipped the hospital to carry out fully comprehensive medical and surgical (including rehabilitative) programs for patients with these specific diseases. In addition, the trustees built and fully equipped one wing of the hospital for basic biochemical and physiological research in these particular diseases.

The relationship between The Good Samaritan Hospital, The Johns Hopkins Medical School, and The Johns Hopkins Hospital was formalized by affiliation agreement which enabled The Johns Hopkins Medical School to expand its research, teaching, and clinical care

programs, and to develop specifically the field of rehabilitation medicine and surgery for the first time. Approximately $250,000 from the O'Neill Trust Endowment has been made available on a continuing annual basis to fund salaries for full-time faculty positions in basic research and clinical care in the areas aforementioned. In addition, remuneration for activities by physicians, both for medical administration in the clinical departments and personal professional services to patients, permits accumulation of additional funds for full-time salaries.

The Department of Medicine of The Johns Hopkins Medical School, which expresses itself clinically in The Johns Hopkins Hospital and the Baltimore City Hospitals, elected to move three of its major clinical divisions (allergy, renal, and rheumatology) to The Good Samaritan Hospital to take advantage of the clinical, teaching, and research facilities. The Divisions of Dermatology, Endocrinology, and Respiratory Diseases of the department have elected to carry out approximately one half of their activities at Good Samaritan. The programs for reconstructive orthopedic surgery and transplantation surgery (particularly renal transplantation and the Department of Neurology's Stroke Program) are in the process of moving to Good Samaritan, located about 3½ miles northeast of Hopkins, approximately 12 minutes ride by automobile.

All anatomical pathology is done at The Johns Hopkins Hospital. Clinical pathology has been achieved on The Good Samaritan site. With gradual centralization of clinical pathology laboratories for all Hopkins institutions, selected segments of complementary clinical pathology will be done in laboratories of the clinical pathology division in either hospital.

In an attempt to fulfill the regionalization concept, certain complex radiographic equipment is not provided at Good Samaritan. Patients are transferred, for instance, to Hopkins for angiographic radiological studies. Central blood depository and processing are accomplished at the blood center located at Hopkins. The blood bank maintained at Good Samaritan deposits its collections and obtains its supplies from the center at Hopkins.

The Good Samaritan Hospital and The Johns Hopkins Hospital, together with three other hospitals in Baltimore City, (Church Home Hospital, Union Memorial Hospital, and The Greater Baltimore Medical Center) have joined in common procurement of supplies and a beginning standardization of equipment by organizing an independent corporation, The Hospital Services and Supply Center, further implementing the regionalization concept.

The Good Samaritan Hospital opened its doors in November of 1968. It has gradually opened its nursing units; there are now 164 beds open, plus a ten-bed renal dialysis unit, the largest in Maryland.

The hospital was fully accredited by the Joint Commission on Accreditation of Hospitals within the minimum time after opening, and has subsequently been accredited by CARF as a rehabilitation facility.

The organization of the clinical programs attempted new and innovative ideas, and overcoming inertia of an ongoing institution. Clinical and administrative department heads enthusiastically entered into these new concepts and programs. The team approach to medical care has been strongly emphasized.

Each of the 36 nursing units has a full-time physician in charge. Under him (or her) work other full-time physicians, fellows, and residents who are either accredited directly for the special care programs, or who rotate from the general medical and surgical residency programs maintained by the Medical School's Departments at The Johns Hopkins and Baltimore City Hospitals, to enable the residents to have an intensive experience in the special care programs mounted at The Good Samaritan Hospital. Fifth year medical students who have completed two clinical clerkships elsewhere are given the opportunity to serve as senior clerks with compensation. Thus, the internship, has been eliminated, an approach which the clinical staff feels is an advance both in patient care and medical education. The aforementioned form the resident staff to care for the attending physician's patient.

One of the nursing units is devoted to care of patients with arthritis and connective tissue disorders and is located on the same floor where the extensive research laboratories for this activity are housed. Two of the nursing units are exclusively for rehabilitation medicine and surgery. Patients on these nursing units have stroke, central nervous system disorders, extensive orthopedic surgical procedures, and the like. Another nursing unit is devoted to care of patients in the cardiac program; and another to care of patients with pulmonary diseases, endocrine disorders, and allergic disorders. Two of the nursing units have concentrated all of the intensive and acute care for patients who have been accepted into the hospital's patient population because of chronic disease and enduring disability, but who have unrelated intercurrent disease such as pneumonia, ulcer, or pulmonary infarction and for whom, in our concept of con-

tinuity of care, acute intensive care has been assured.

No emergency room is operated for off-the-street emergencies, but any patient who has been accepted into one of the hospital's special care programs is given care 24 hours a day, seven days a week, including emergency level of care in appropriate facilities. Ambulatory facilities are also maintained on The Good Samaritan lot for post-discharge care of patients who elect to continue under care of physicians in the special care programs. Some of the posthospital care is given—particularly to residents of East Baltimore—in the special clinics operated in Hopkins' Outpatient Department by physicians mounting the special care programs.

The team approach is utilized in the care of all patients. The physician serves as captain. There is strong emphasis on nursing, particularly rehabilitative nursing, social service, psychology, physical and occupational therapy, the spiritual ministry with active clergy participation, and clinical pharmacology with active participation of the pharmacists in day-to-day care of patients. All patients admitted to any of the special programs mounted by the hospital are surveyed after the initial physical examination by the appropriate medical specialty and paramedical specialties. Once the initial evaluation by each individual discipline has taken place, a group conference is held to determine the program of care and rehabilitation, and to chart the time course in which this care program is to be achieved. All patients received are thoroughly worked up by social service, there being a professionally trained medical social worker assigned to each 36-bed unit. The family of each patient plays an integral role in planning for the care of each patient. Discharge planning is begun the day of admission. The family is very much involved in the discharge and posthospital continuing care plans.

Private practitioners on the staff of the hospital admit their own patients and serve as the physician of record, ie, the responsible physician. The team concept is also utilized with these patients. Patients admitted on referral from health agencies and family physicians who do not have privileges at The Good Samaritan Hospital, and upon transfer from other hospitals for more intensive and extensive rehabilitation care, are placed under care of the full-time physician faculty member who is in charge of the particular nursing unit appropriate for the patient's needs.

In the first year of operation there were 800 admissions; 50% were referrals from family physicians not having staff privileges. The other 50% were transfers from other hospitals, the majority from Hopkins. Other patients came from hospitals throughout the greater Baltimore area, and in ten instances from out-of-state hospitals. In every instance of outside referral, the referring physician is encouraged to take an active part in the care of his patient, although the ultimate legal responsibility, of course, rests with the physician of record, ie, the staff member to whom the patient has been assigned upon admission.

The special programs encourage greater family participation. The nursing program is particularly oriented to teaching the family appropriate rehabilitation techniques. Follow-up of discharged patients is maintained by a public health nurse member of the nursing staff with frequent follow-up contact with patient, family, and referring physician or agency to insure continuity of care. While this has been successful in about 60% of the discharges, a follow-up study of patients originating from the inner city of Baltimore indicates a severe lack of posthospital care at other institutions, or from the family physician—even when such care was originally arranged at the time of discharge. The inability of the family or patient to follow the program without guidance has been the major cause of this lack. This is especially so in instances where physical therapy in hospital had been extensive. Follow-up has indicated regression to that physiological state akin to that at the time of the original admission.

The opening of a new hospital such as this with special programs new to the City of Baltimore—to both its physicians and its citizens at large, and to the State of Maryland—has not been without its problems. Financial backing for patients, particularly those under Medicare transferred for extensive rehabilitation guaranteed under Public Law 8997, has been lacking. Guidelines have never been developed for this provision of the law. The cutback in provision of extensive hospitalization under recent interpretations by the fiscal intermediary for Medicare in Maryland has prohibited full rehabilitation for many patients.

The Maryland licensing authority found it difficult to classify the hospital since it is a special hospital engaged primarily in medical, surgical, and rehabilitative activities. The original encompassing term "Chronic Disease Hospital" utilized in the license granted created severe "semantic" problems for the hospital since third-party payers, including Government (Medicare and Medicaid), Blue Cross, and private health insurance companies all equate a "Chronic Disease Hospital" to custodial care activities and have a difficult time understanding that it encom-

passes intensive medical, surgical, and rehabilitative levels of care for specific patients who have specific diseases which are permanent and which cause enduring disability.

The Good Samaritan Hospital (a product of the union of three great institutions: the Roman Catholic Church, The Johns Hopkins University, and the Daughters of Charity of St. Vincent de Paul, a Catholic order of Nuns engaged in nursing), looks forward with enthusiasm to carrying out this new and innovative mission providing comprehensive and continuous care for patients with long-term illnesses causing enduring disability.

Lawrence Cardinal Shehan is the president; John Collins Harvey, MD, is executive vice president and medical director; and Aileen E. Foley is the administrator.



INTENSIVE CARE—A nurse at the monitoring station in the intensive care unit monitors a patient (right) for myocardial infarction.



DIALYSIS—A ten-bed dialysis unit (right) is maintained for chronic renal dialysis of the anephric patient awaiting kidney transplantation. The dialysis machine (left) is being operated by the technician and one of the overseeing physicians.







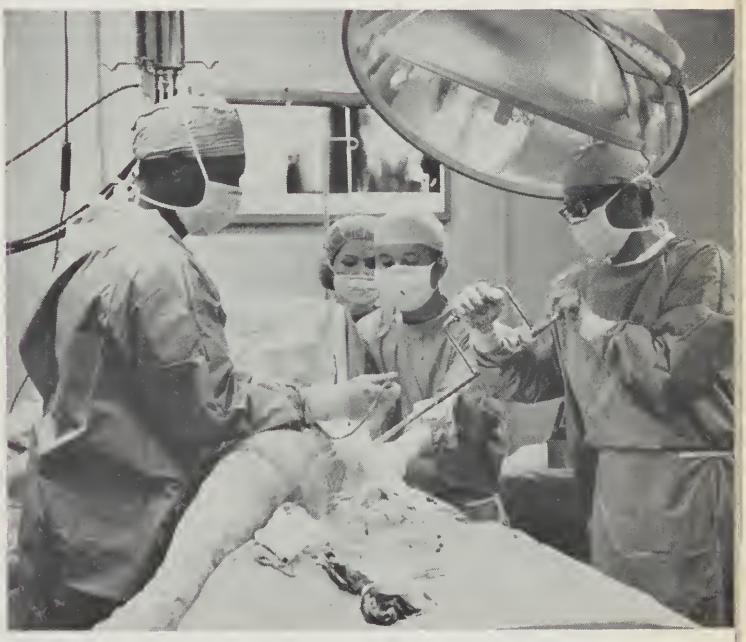
ROUNDS—Drs. Angel Achurra and Jerry Parent make the rounds with Dr. Mary Betty Stevens. Dr. Stevens is in charge of the special arthritis and connective tissue care program, recently recognized in Medical World News as the most outstanding combined clinical and laboratory program in the United States.



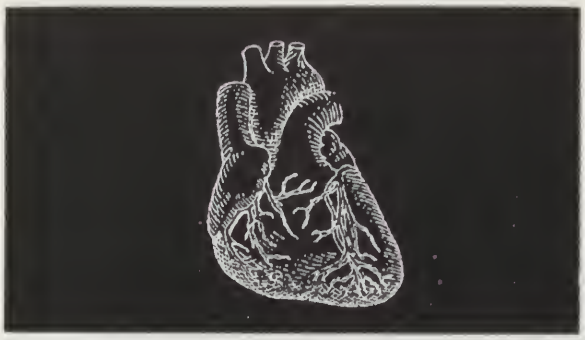
BACTERIOLOGY LAB—Because of its excellence, the Bureau of Laboratories of the State Department of Health recently selected this lab as a reference laboratory for bacteriology. (A reference lab in bacteriology is used by other hospitals that send their problem cultures for further identification and assistance.)



PULMONARY LAB—A patient with emphysema is being studied following treatment by one of the pulmonary technician therapists. This is part of the extensive program for patients with severe obstructive pulmonary disease.



OPERATING ROOM—A total hip replacement operation is being done by Dr. Norton I. Gettes, orthopedic surgeon, right. Other team members, from the left, are John Brown, technician; Dr. A. Ninneman, anesthesiologist; and Abraham Tan, technician.



MORRIS N. KOTLER, MD, EDITOR

*A Service of the Heart Association of Maryland*

**the heart page**

# PITFALLS OF THE ELECTROCARDIOGRAM

**CHRIS PAPADOPOULOS, MD**
**Chief of Cardiology**
**South Baltimore General Hospital**
**Baltimore**

The invention of the string-galvanometer electrocardiograph by Einthoven in 1903 provided a new, important tool in the diagnosis of heart disease. Eccentricities of the electrocardiogram, however, lead at times to errors in diagnosis and prognosis, making the defenseless patient a victim of electrocardiography.

It is well known that a normal electrocardiogram does not rule out heart disease. Patients with angina pectoris frequently have normal EKGs. A single, normal EKG is also worthless in ruling out an acute myocardial infarction. Significant changes may develop hours or days later. This should not minimize the value of the standard, 12-lead EKG which, in the majority of cases, remains the most specific and accurate test leading to the diagnosis of myocardial infarction. A normal EKG does not also exclude the possibility of previous myocardial infarction. In one study 31% of cases failed to show diagnostic evidence of the previous myocardial infarction one half to one year later.[1]

In many instances of acquired valvular disease, until the disease significantly alters the intracardiac pressure and flow relationships, coronary blood flow, and size of the cardiac chambers, the electrical forces may not be altered sufficiently to be detected on the body surface. Stenosis or insufficiency of the mitral, aortic or tricuspid valve, or a combination of these are not infrequent examples. At times severe aortic stenosis with a gradient across the valve of up to 100 mm of mercury is present with a normal EKG. There is also a group of patients with heart disease who have had cardiac surgery and whose abnormal preoperative EKG has returned to normal after correction of the defect.

The electrocardiogram may also be normal in many cases of congenital heart disease. Single valvular or septal defects often cause no electrocardiographic changes.

At times the presence of EKG abnormalities makes difficult the interpretation of an associated lesion. Left bundle branch block, Wolff-Parkinson-White Syndrome, ventricular tachycardia, heart block, or previous myocardial infarction may mask the evidence of a recent infarct. The EKG may not be as helpful in the diagnosis of recurrent myocardial infarction as it is with an initial infarct. In a recent study,[2] however, supported by autopsy findings, it was stated that further increases of preexisting ST segment elevation or depression, deeper inversion of already inverted T waves, and further deepening and widening of pathological Q waves may all aid in making a diagnosis of a recurrent, acute myocardial infarction. In the absence of these EKG findings, particularly in the light of good clinical findings, alterations in cardiac rhythm or development of intraventricular conduction disturbances should make one suspicious of an acute infarct. Frequent tracings are more important when dealing with second episodes of infarction, as the changes may be subtle and may not occur as early in the course of the illness.

The presence of right or left bundle branch block makes very difficult the diagnosis of associated right or left ventricular hypertrophy. P-mitrale and P-pulmonale may indeed be due to left or right atrial hypertrophy as is often substantiated by postmortem examination, but the same P waves may be produced by atrial conduction disturbances without atrial hypertrophy.

The electrocardiogram may be abnormal in the absence of heart disease. Hiss and Lamb[3] studied the electrocardiograms of 122,043 apparently healthy male subjects age 16 to over 50 years and found EKG abnormalities in 4.72%. Right bundle branch block was found in .18% and left bundle branch block in .03%. Nonspecific T wave changes were noted in 1.15%.

Physiologic stimuli may cause EKG changes which, unfortunately, at times simulate ischemic heart disease. An electrocardiogram recorded with the patient in the upright position, or after eating, or after drinking ice water may show T wave changes.[4] Anxiety and tachycardia may cause ST-T changes. Fear and hyperventilation may cause inversion of the T waves. Repeating the EKG after a few hours of fasting or with deep inspiration or during breath holding may help prove the benignity of the previous changes.

Normal variants may also simulate ischemic heart disease. Persistence of the T wave inversion in the right precordial leads up to early adulthood may be noted in 10.8% of Negro males.[5] Marked elevation of the ST segments in several chest leads, sometimes up to 4 mm, is also more common in black people.

Misplaced precordial electrodes may also produce a tracing with an "abnormality." On the other hand, when the heart is in an unusual position, such as in patients with chest deformities or an abnormally high or low diaphragm, even with the electrodes in the conventional positions, one may get an "abnormal" EKG which may be corrected by obtaining a recording from more than one interspace in each vertical V line.

At times noncardiac disease can cause EKG changes. Acute cholecystitis, acute pancreatitis, perforated viscus, and cerebrovascular and intracranial lesions may cause EKG changes that often simulate ischemic heart disease.

In summary, while a normal EKG does not exclude heart disease, an abnormal one does not always mean an abnormal heart. This is important to consider in order to avoid errors in diagnosis and prognosis. The teaching of the Hippocratic School was "Make a habit of two things—to help or at least to do no harm."

**References**


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# SEPTEMBER 14, 15, 16, 1972

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**SCIENTIFIC SESSIONS — CONVENTION HALL**

FRIDAY, SEPTEMBER 15 — Session cosponsored by Maryland Radiological Society

*ALL PHYSICIANS INVITED TO ATTEND THIS PROGRAM OF GENERAL INTEREST*

2:00 to 3:30 PM—*THE ROLE OF CORONARY ARTERIOGRAPHY IN THE DIAGNOSIS AND TREATMENT OF CORONARY DISEASE*

**Herbert L. Abrams, MD,** Cook Professor and Chairman of the Department of Radiology, Harvard Medical School

*PANEL DISCUSSION* to follow *including*

**Vincent L. Gott, MD,** Richard Bennett Darnall Professor of Surgery, The John Hopkins University School of Medicine

**Leonard Scherlis, MD,** Professor of Medicine and Head, Division of Cardiology, University of Maryland School of Medicine and *moderated by*

**John B. Hearn, MD,** Department of Radiology, St. Joseph Hospital, Towson, Md

This discussion will concern itself chiefly with the indications and usefulness of *BYPASS SURGERY* in coronary diseases.

SATURDAY, SEPTEMBER 16

10:00 — 11:00 AM — **John O. Sharrett, MD,** Instructor in Neurosurgery at the University of Maryland School of Medicine will discuss neurological contrast studies.

11:00 AM — 12:30 PM — A program on medical economics will be presented by the **Committee on Medical Economics** of the Medical and Chirurgical Faculty.

**BUSINESS SESSIONS** — CONVENTION HALL

THURSDAY AFTERNOON, SEPTEMBER 14,—MEETING OF THE COUNCIL OF THE FACULTY

FRIDAY MORNING, SEPTEMBER 15—MEETING OF THE HOUSE OF DELEGATES OF THE FACULTY

**SOCIAL FUNCTIONS**

FRIDAY EVENING, SEPTEMBER 15,—CONVENTION HALL

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**SEPTEMBER 14, 15, 16, 1972**

Albert M. Antlitz, M.D. Chairman
Committee on Program and Arrangements

# 140/90 is normal blood pressure...or is it?

## An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

**Study Findings.** Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"[1]—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

**Other Studies.** Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

**Another Point of View.** Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."




**Drug Therapy for Hypertension.** Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

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# HydroDIURIL®

(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Kannel, William B., *et al.*: "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Consultant, Jan. 1971.

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# HydroDIURIL®

## (Hydrochlorothiazide|MSD)

## Therapy to Start With

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**CONTRAINDICATIONS:** Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

**WARNINGS:** May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

**PRECAUTIONS:** Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Hypochloremic alkalosis occurs infrequently and is rarely severe. In severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur if dietary salt is unduly restricted, especially during hot weather.

Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics.

Pathological changes in the parathyroid glands with hypercalcemia and hypophosphatemia have been seen in a few patients on prolonged thiazide therapy. The effect of discontinuing thiazide therapy on serum calcium and phosphorus levels may be helpful in assessing the need for parathyroid surgery in such patients. Parathyroidectomy has elicited subjective clinical improvement in most patients, but has no effect on hypertension. Thiazide therapy may be resumed after surgery.

Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. May affect insulin requirements in diabetics; may induce hyperglycemia and glycosuria in latent diabetics.

**ADVERSE REACTIONS:** Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, cholestasis, and pericholangiolitic hepatitis. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, transient blurred vision, sialadenitis, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have linked thiazides to pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. When adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn.

*For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486*

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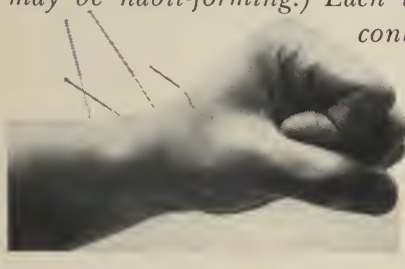
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**Contraindications:** Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.
**Precautions:** Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
**Side effects:** Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.
**Dosage:** Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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and the Latin **sedatus,**
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**Indications:** Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

**IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media.**

**Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.**

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

**Contraindications:** Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

**Warnings:** Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

**Precautions:** Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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**2.**

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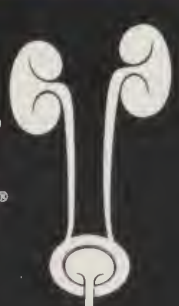
*Koch-Weser, J., *et al.: Arch. Intern. Med.*, *128*:399, 1971.

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**Usual adult dosage:**

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2 to 4 tablets *q.i.d.*




NEIL SOLOMON, MD, PhD, SECRETARY

**Maryland State department of health and mental hygiene**

# MENTALLY RETARDED: NO LONGER SOCIETY'S FORGOTTEN CHILDREN

**ROBERT E. DeHAVEN**
**Regional Director**
**Mental Retardation Administration**
**Department of Health and Mental Hygiene**
**Baltimore**

In the past ten years, there has been a change in attitudes among the citizenry of Maryland regarding the problem of mental retardation. Prior to that time the retarded had been isolated from the rest of society. They were housed in rurally located institutions and separated from the mainstream of community life. As long as their basic physical needs were being met, the great majority of people were apathetic to the numerous problems created by institutionalization and the need for community programs.

It is now recognized that isolation of the retarded, in large institutions, has increased the cost of care and deprived retardates of their natural rights of happiness and self-fulfillment. In addition, the institution has not encouraged or done adequate training for return to the community. Generally, these large facilities have been overcrowded, costly to maintain, and lacking in appropriate programs. Two of the most effective ways to assure appropriate services for the mentally retarded are to keep as many retardates as possible in the community so that they remain an integral part of the family and society, and to drastically reduce the number of persons in residential institutions.

A Mental Retardation Administration was created for the purpose of unifying all of Maryland's programs for the retarded. The Administration is responsible for developing, coordinating, maintaining, and expanding programs. All programs for the mentally retarded, formerly administered under the Departments of Health and Mental Hygiene, are now the responsibility of the Mental Retardation Administration. In addition, this new department will work closely with local and State organizations in planning for the future.

The needs of the retarded are basically the same as those of the normal person. Just as with a normal child, a retarded child needs education, medical care, a warm home environment, love, training, counseling, etc. A retarded child and/or adult may require the same services as a normal person, but at a more frequent rate and for a longer period of time. The provision of these services to the retardate and his family, when they are needed and in the amounts required, is the basic task facing State and local authorities planning new facilities, services, etc, for the retarded.

The Mental Retardation Administration has accepted as one of its goals the provision of a continuum of services to the retardate and his family as close to home as possible. These services would include a prevention program, special medical care, training facilities, etc. These types of services will be discussed briefly.

An important part of the continuum is a good preventive program. At this time, Maryland is giving much attention to such a program. Such measures as improved prenatal programs, inoculation against rubella, nutrition programs for expectant mothers, genetic counseling for parents, and medical examinations utilizing amniocentesis will reduce the percentage of retarded individuals in the future. However, with the increasing population, the overall number of mentally retarded people will continue to rise.

Just as important as preventive programs is the need to offer vigorous continuing supportive services to the families of the mentally retarded. These services will not only help the family understand the retardate's development, but assist them in sustaining their retarded child at home. The family physician, pediatrician, or

local health nurse are usually the first people to be contacted when parents suspect their child is retarded. In cases where the parents do not suspect mental retardation, the first evidence is usually discovered through the public school, and referral to the appropriate services may be handled by the local physician or the school. The Mental Retardation Administration, through its regional staff, can aid in the selection of the most appropriate resource for the child and in this way offer service to local individuals or communities.

Once the child's condition has been diagnosed and an evaluation completed, community programs must be available. These programs must meet the different ability levels and home situations of the retarded. The programs must be comprehensive to provide for the retardate's changing needs throughout his life. Day care centers which provide training for the young retardate are being expanded every year. The child is then able to remain in the home while attending a center in order to gain training in basic self-care skills such as dressing, toileting, and acceptable behavior. The family is given counseling so that they can help with the training at home.

The type of training offered by day care centers is basically of two types. There are preschool programs for children three to six years of age focusing on self-help and social development. For those children six to 16 years of age, who do not fit into an established school program, training in socialization, recreation, and other activities is varied according to the retardate's abilities and needs.

Many young and older adults will continue to need services outside the home; therefore, Maryland is developing activity centers to meet these needs. Here, in addition to those who have grown up in day care centers, will come referrals not only from trainable classes but from residential programs as well.

In these programs, older retardates receive advanced training in basic self-help skills, social skills, and recreation programs. The retardate is taught to be a contributing part of the family. Pre-vocational programs are also offered in many activity centers so that the retardate can participate in a sheltered workshop. In short, the mentally retarded person is given the skills necessary for him to function in the home and community. If it is felt that he can function adequately in a work situation, the Department of Vocational Rehabilitation will offer work training and needed supportive services.

However, there are still those mentally retarded individuals who may need residential programs for short- or long-term care. Some may be referred because of medical problems, others because of the inability of their families to care for them.

Regional residential facilities are being constructed in Maryland. Since these centers will be near the retardates' homes, parents will be able to maintain close relationships with their children. The staff of the centers will counsel parents in the areas of care, feeding, and behavioral management. With the close proximity of the centers, it will be routine for the retardate to go home for weekends or short visits when the family and center feels it is appropriate. The available space can be used for short-term crisis intervention and thereby reduce the need for long-term care.

These centers will have to be comprehensive and offer the full range of services to the retardate and his family. It should be emphasized that such services will not duplicate existing programs. Local Departments of Social Services, Health, Education, etc, offer many of the services the retardate and his family require. Regional centers will complement these services, and act as back-up facilities to local agencies.

Past experience has shown that regional centers have to be small, so that the resident is not lost in the tremendous task of administering a large facility. Living space should be homelike in appearance, and allow for more individual attention for each resident, as well as affording him with the common, everyday necessities of life, such as appropriate clothing, the opportunity to practice good table manners, etc. Therefore, the Mental Retardation Administration has planned small comprehensive centers to be located in various regions throughout the State.

Some of the retardates who have lived in residential facilities gain enough self-care and social skills so that they no longer need the constant supervision that the residential center provides. Many others acquire vocational and social skills and are able to function in the community with minimal supervision. Group homes have proven to be quite successful for these people. Maryland is presently expanding its program of group homes and foster homes for the retarded. In this way, retardates are able to remain in or return to the mainstream of community living.

Maryland has taken action which will benefit the mentally retarded. The establishment of an Administration of Mental Retardation will provide the leadership necessary to develop programs for the mentally retarded and their families. It will further carry the responsibility to provide or procure services that will include prevention, parent counseling, day care, activity, residential programs, and halfway houses.




ROBERT E. FARBER, MD, MPH, COMMISSIONER

**Baltimore City health department**

# ACCIDENTAL POISONING TRENDS

A five-year comparison of statistics on accidental poisonings reported from 22 Baltimore hospitals and clinics that treat such cases shows that reported cases of accidental ingestions rose for the fifth year in a row. Last year, 4,384 persons were reported as accidental poisoning cases, an increase of 73 over 1970. A compilation is made annually by the City Health Department's Bureau of Biostatistics from monthly reports from emergency rooms and pediatric clinics. While this report does not include persons seen by private physicians or those that treated themselves without consulting a physician, it does show some significant trends in the city's accidental poisoning cases.

Accidental poisoning from internal medicines continues as the most common cause of poisoning. In 1971 there were 2,779 internal medicine poisonings or 204 more than were reported in 1970. While aspirin remains the single internal medicine that causes most accidental poisonings, there were fewer aspirin cases reported for the second straight year. Last year's total of 401 aspirin poisonings was 164 fewer than in 1970. Reported cases of both the second and third leading cause of poisonings declined. Household preparations, the second leading cause — a group which includes washing and cleaning products, pesticides, cosmetics, polishes, paints, and solvents — fell 140 cases, from 886 in 1970 to 746 in 1971. External medicines, the third leading cause, fell by 31 cases from 138 in 1970 to 107 in 1971.

Drug abuse poisonings continued to rise, as they have over the last five years. Last year there were 1,714 persons reported treated for poisoning due to depressants, stimulants, narcotics, or psychopharmaceuticals, or 370 more than were reported in 1970. Accidental poisoning deaths rose from 77 in 1970 to 90 in 1971; 84 of these deaths were from narcotics. The narcotic death victims ranged in age from 14 to 45.

How important the drug abuse problem has become was demonstrated by 1971's accidental poisoning reports. Where previously accidental poisoning was most common between ages one to four, in 1971 persons 12 to 24 years old (the years of experimentation and addiction) have become the most likely poisoning victims. While cases involving them went up by 543 in 1971, children from one to four years of age were involved in 477 fewer cases. It is believed that parents' awareness of their responsibilities in preventing poisonings of preschool children plus some helpful packaging assistance from manufacturers has helped to reduce poisonings in the preschool years.

During 1972 the Maryland Poison Prevention Committee will be attempting to bring the accidental poisoning problem to the attention of Metropolitan Baltimore residents by every means possible. This committee comprises representatives of the Maryland State Department of Health and Mental Hygiene, the Baltimore City Health Department, the Maryland Pharmaceutical Association, the Maryland Chapter of the Academy of Pediatrics, the Baltimore Safety Council, the Federal Food and Drug Administration, the Medical and Chirurgical Faculty of Maryland, and the Baltimore City Medical Society.

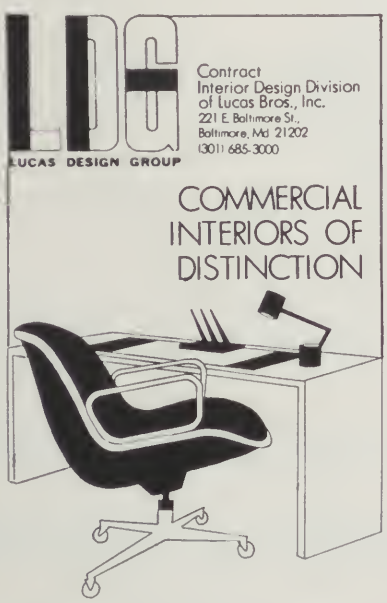
This year's goals will be to lower the descending accidental poisoning rates even further, to turn the rising rates into decline, and to make poison prevention a year-round campaign. Physicians are urged to alert parents to the poisoning danger for likely poisoners of the preschool child and urge them to put such items under lock and key or at least out of sight and out of reach. It is also recommended that parents learn more about the problem of drug abuse and how to combat it.

# TUBERCULOSIS STUDY

The City Health Department's Division of Tuberculosis, in conjunction with Elmer P. Sauer, MD, medical superintendent at Mount Wilson State Hospital, and Richard L. Riley, MD, chairman and professor of Environmental Medicine at Johns Hopkins University, has begun a study to compare the effects of drug therapy on active tuberculosis cases and their families when treatment is carried out in hospital and at home. Similar studies have been carried out in other countries and these have established beyond doubt that home treatment is just as good and as safe as treatment in a hospital. Some doubt has been cast on these studies on the grounds that both the infecting agent and the patients are different.

The object of the study is to determine on a purely local basis whether or not it is necessary to subject tuberculosis patients who are otherwise well to a prolonged incarceration in a hospital, and at the same time to establish if the extra effort required to maintain patients on drugs at home costs significantly less than treatment in hospital. The study could result in substantial savings which would otherwise increase with the rising costs of hospital treatment. Unfortunately, by reason of the present method of budgeting, any savings earned would not accrue to the program, but at least it would be hoped that the patients would benefit.

The program will be conducted on the normal operating budget of the City Health Department's tuberculosis division with support from the National Tuberculosis and Respiratory Diseases Association, administered through the Maryland Tuberculosis Association.




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## Meaning of NAS/NRC Findings In Prescription Drug Advertising and Labeling

### Background

The Amendments of 1962 to the Federal Food, Drug, and Cosmetic Act, authorized the FDA to review available evidence of effectiveness on many drugs marketed between 1938 and 1962. Specifically, the Amendments provided that after a two-year grace period, the effectiveness of such drugs should be supported by adequate and well-controlled clinical investigations. Until 1962, evidence on effectiveness had been considered in evaluating new drug applications only when it related to patient safety. Of course, long before 1962, the FDA had authority to remove any drug product from the market whenever it could prove that it would not perform as claimed or was deemed dangerous to health when used as directed.

In 1966, the FDA asked the National Academy of Sciences for assistance in assessing the evidence supporting the effectiveness of pre-1962 drugs. Consequently, and in cooperation with FDA and industry, the NAS/NRC appointed 30 six-man panels to review these drugs and frame recommendations to the Agency. Only evidence available through 1966 was considered. The panels conducted no research.

Panels rated each drug or drug claim as "effec-

tive," "probably effective," "possibly effective," "ineffective," "effective, but," or "ineffective as a fixed combination." These recommendations were transmitted to FDA by the NAS/NRC. Many drug products received mixed or indecisive evaluations. For example, some drugs were reviewed by more than one panel and received different recommendations from each. Drugs with several claims frequently received varied ratings. It should be noted, too, that the consensus of a panel was not a recommendation of the NAS/NRC and, of course, had no legal effect.

FDA then considered the panel recommendations along with any other information at its disposal, and began regulatory action which has taken the form of 1) a notice of effectiveness; 2) a request for change in labeling claims; 3) a request for more evidence, including clinical trials; 4) a request that the drug be reformulated; 5) or a proposal to remove the drug from the market. It should be emphasized that an initial notice in the *Federal Register* on implementation comprises only a first step in the process provided for in the Act for deciding a drug's effectiveness. Thus, much like a court case, there can be no presumption of a product's lack of effectiveness until all evidence is mustered.

FDA has now ordered that prescription drug labeling and advertising contain NAS/NRC panel findings other than "effective." This order becomes applicable only when an FDA implementation notice appears in the *Federal Register*. In those instances, when FDA disagrees with the NAS/NRC findings, the FDA finding will supersede and will appear instead of the panel finding. Thus, long before the issue of effectiveness is finally resolved, physicians will be informed of, and pharmaceutical manufacturers will be required to abide by, FDA's opinion.

It should be emphasized that FDA classifications of "less than effective" apply only to particular indications, not to products *per se,* and will so appear in labeling and advertising.

The following statement delineating what the panels considered the classifications to mean are derived from the guidelines for the review published by the National Academy of Sciences, Division of Medical Sciences, and from the final report of the study published by the same group.

## Findings

In the main, the findings relate to the availability (or lack of availability) of certain types of evidence rather than to the actual effectiveness of the drugs.

**"Effective"**—For the presented indication, the drug is effective on the basis stated.

**"Probably Effective"**—Effectiveness for the particular indication is probable but additional evidence is required before the drug can be finally assigned to the "effective" category. Modification of claims may be all that is needed. In some cases, the panels believe drugs in this category are effective on the basis of clinical experience but lack adequate and well-controlled studies.

**"Possibly Effective"**—There is insufficient evidence of effectiveness under the criteria listed for the study. However, in some cases here, as well as in the "probably effective" category, the panels believed the drugs to be effective on the basis of clinical experience. The panels were not always consistent with each other in the use of this and the "probably effective" rating.

**"Effective, But"**—Panels applied this rating to drugs for which there was substantial evidence of effectiveness, but which they considered inferior to other drugs. This category is surprising since the Food and Drug Act does not permit the FDA to consider relative effectiveness in exercising its authority over drugs. It also was used to draw attention to so-called vaguely worded or misleading claims.

**"Ineffective as a Fixed Combination"**—This category does not involve effectiveness in its usual sense but rather reflects basic philosophical attitudes toward fixed combination products. Thus, the final report states that multiple therapy using fixed dose ratios, determined by the manufacturer and not by the physician, is in general, poor practice. The findings "effective, but" and "ineffective as a fixed combination" are usually changed by FDA prior to publication to one of the other findings listed herein.

**"Ineffective"**—There is no acceptable evidence as to effectiveness.

The service performed in general by the NAS/NRC review panels was outstanding and panel members and NAS/NRC staffers are to be commended for ably carrying out a complex task in a short period of time. However, because of the factors enumerated, each finding must be considered individually. It should not be regarded necessarily as immutable doctrine but only as limited opinion on a question of drug therapy. Further, final decisions have not been made on many drugs. They remain available pending the development of further evidence.

Significantly, the panels themselves wrote as follows in the final report: "The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."



## PROTEIN CONTENT / 1 Cup Prepared Soup*

| | | | |
|---|---|---|---|
| Bean with Bacon | 7.7 | Green Pea | 7.8 |
| Beef | 9.1 | Hot Dog Bean | 8.6 |
| Chicken Broth | 8.4 | Oyster Stew | 6.0 |
| Chicken 'N Dumplings | 6.6 | Pepper Pot | 6.9 |
| Chili Beef | 7.0 | Split Pea with Ham | 11.6 |
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*References.* **1.** Editorial: Oral Contraceptives: Which Pill for Which Patient? Patient Care *3*:90-115 (Feb.) 1969 and *4*:135-145 (June 15) 1970. **2.** Greenblatt, R. B.: Progestational Agents in Clinical Practice, Med. Sci. *18*:37-49 (May) 1967. **3.** Kistner, R. W.: Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W.: The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H.: Clinical Evaluation of Side Effects of Current Oral Contraceptives, J. Reprod. Med. *6*:50-55 (Feb.) 1971. **6.** Orr, G. W.: Oral Progestational Agents: Therapy and Complications, S. Dakota J. Med. *22*:11-17 (Jan.) 1969.

## the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slight progestogen dominance. It has an excellent record of patient acceptance.

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Each white tablet contains: ethynodiol diacetate 1 mg., mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information, see following page.



## the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

# Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen 28* and Demulen* 28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

## the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

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# Demulen®

Each white tablet contains:
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Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1,3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in $T^3$ uptake values; metyrapone test and pregnanediol determination.

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norethynodrel 2.5 mg./mestranol 0.1 mg.

**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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dvertisement

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*—George Sarton, from "The History of Medicine Versus the History of Art"*

# Would it be useful in clinical practice to have government predetermine drugs of choice?

# Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

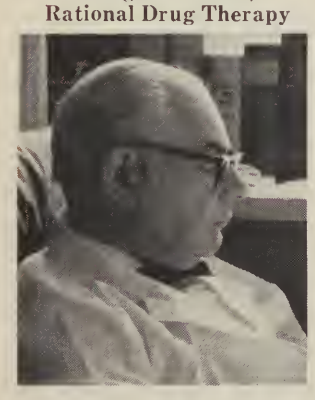
86.7%
No, it would not be useful.

# Dialogue

# Would it be useful in clinical practice to have government predetermine drugs of choice?

## Doctor of Medicine

**Walter Modell, M.D.,**
**Professor of Pharmacology,**
**Cornell University**
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**Clinical Pharmacology**
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**Drugs of Choice,**
**Rational Drug Therapy**



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. And I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the one "drug of choice" in all areas of medical practice.

# Maker of Medicine

enneth G. Kohlstaedt, M.D.,
Vice President,
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Eli Lilly and Company



In my opinion, it is not e function of any governent or private regulatory ency to designate a "drug choice." This determinaon should be made by the ysician after he has reived full information on e properties of a drug, d then it will be based on s experience with this ug and his knowledge of e individual patient who seeking treatment.

If an evaluation of comarative efficacy were to be ade, particularly by govnment, at the time a new ug is being approved for arketing, it would be a eat disservice to medine and thus to the patient the consumer. For exame, when a new therapeuc agent is introduced, on e basis of limited knowlge, it may be considered be more potent, more ffective, or safer than roducts already on the arket. Conceivably, at is time the new drug uld be labeled "the drug f choice." But as addional clinical experience is ccumulated, new evidence ay become available. ater, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audio-visual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin $B_{12}$ as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

## Opinion & Dialogue

**What is your opinion, doctor?**
**Send us your comments on the above issue.**

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# DEPRESSION—A MOOD DISORDER IN CHILDREN AND ADOLESCENTS

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*Delivered at the Taylor Manor Hospital Psychiatric Symposium, Ellicott City, Md, Oct 2, 1971.*

*Information and reprint requests to Dr. Bakwin at 550 First Ave, New York, NY 10016.*

There is a growing awareness of the frequency of depression in children. Only during the last few years have a number of papers appeared describing the syndrome in children. The reasons why it has escaped attention for so long are understandable. For one thing, children are themselves unaware of the meaning of depression and do not complain about it, as do adolescents and adults. Nor do parents and physicians think of children as being depressed. In addition, the characteristic symptom—an appearance of sadness and unhappiness—is often masked in children by other behavioral manifestations, especially aggressive behavior and poor school performance.

Opinions differ as to the frequency of depression in children. According to Frommer,[1] one out of five children referred to her are victims of this unhappy ailment. Perhaps its frequency at her clinic is because she is known to have a special interest in the condition. I have not found it to be so common. Children's moods are more unstable than those of adults and unhappiness and joy alternate with great frequency. The transient mood of depression should be distinguished from the more severe and prolonged state.

## Symptoms[2-8]

The core symptom of depression in children, as in adolescents and adults, is a mood change characterized by an appearance of sadness and unhappiness. The child is dissatisfied with the world around him and gets no fun out of anything he does. He mopes, is listless, apathetic, spiritless, dejected. Interest in school work lapses and the child sometimes refuses to go to school. This should not be confused with school phobia. In school phobia the outstanding symptom is anxiety, usually separation anxiety. In the depressed child the basis is lack of interest or even actual distaste for school.

A prominent symptom is loss of self-esteem. The child regards himself as a failure—a jerk, a flop. He feels unloved and rejected and tends to hold others responsible for his plight.

Somatic complaints are frequent—poor appetite, insomnia, headache and dizziness, stomach ache. The poor appetite may be a presenting symptom and may actually be accompanied by loss of weight.

An account of how depression adversely affects appetite was given by Widdowson.[9] Shortly after World War II she was assigned to plan the feeding of children in two German orphanages. In one of these, a supplement was added to the diet; in the other, the rather skimpy diet was unchanged. At the same time the directresses of the two orphanages were interchanged. Surprisingly, despite the improved dietary intake, the children failed to make the expected weight gain. At the other orphanage, where no improvement had been made in the diet, the children showed surprisingly good gains. The reason for this paradoxical result was the exchange of directresses. The directress at the orphanage where the dietary improvement had been made was a martinet, and she seemed to be particularly cruel at meal times. The children feared and hated her. At the other orphange the directress was known for her kindness and gentleness and her affection for children. Widdowson's report is illuminating. Mood changes should be taken into account in studies of undernutrition in children—even in small infants. I shall discuss this later on.

Although an aversion to food is the more common reaction to depression, one sometimes gets the opposite reaction—increased eating. On one occasion, when I told a mother about the severe illness of her child, she said: "I suppose I will get fat again like I did when my father was ill."

The situation is similar in the case of sleep. Insomnia, restless sleep, is the usual complaint of the depressed child; hypersomnia is seen in some. The symptoms of depression have been characterized as bipolar — anorexia-polyphagia, insomnia-hypersomnia, and agitation-withdrawal.

A somatic complaint, which is often the presenting symptom of depression in a child, is head-

ache. Its frequency as a symptom of depression has been emphasized by Ling and co-workers.[10] They studied 25 children in whom headache, unassociated with neurologic disease, was the chief complaint. In ten of these (40%) the characteristic mood change of depression was found. Prominent associated symptoms were social withdrawal and self-depreciation. A family history of depression was obtained in nine out of the ten depressed children.

Many of the children complaining of headache were classified as having migraine; ie, the headaches were unilateral; they were associated with nausea and vomiting; they were accompanied by visual aura; and there was a family history of similar headaches. Depression was as frequent in the children with nonmigraine headaches as in those with migraine. Headaches in the ten children with depression improved, usually markedly, when they were given antidepressant medication.

Depression in the child is often masked by aggressive behavior and irritability. The depressed child is apt to be quarrelsome, belligerent, picking fights and arguments, being rude to his parents, resisting suggestions.

Depression — an appearance of sadness, unhappiness, misery—is the most striking psychologic feature of the emotionally deprived infant. I refer to the babies that we used to see in institutions for orphans and abandoned babies, as well as in hospitals where infants remained for extended periods. Formerly, up to the first decade or two of this century — perhaps the third decade, also — the death rate in institutions for the care of these infants was 100% — they all died, regardless of their health status on admission.[11] At one of these institutions, the admission card of each little patient carried the designation "desperately ill" although he may have been a chubby, rosy baby. The phenomenon of the emotionally deprived baby — referred to as hospitalismus — was widespread. It was seen in all parts of the United States and in Europe and Latin America as well. Although the babies were offered diets adequate for proper weight gain in the home, they withered away in the institution and died. Usually they accepted the food offered; nevertheless they failed to gain weight and often lost. Apathy, listlessness, pallor, a loss of sucking habits, immobility, frequent stools, and fitful sleep were other features.[12,13]

A significant sign was the lag in the response of the infant to a smile with a smile which appears normally sometime between five and eight weeks. Accompanying the smile, the baby becomes animated, coos, and moves his arms and legs; he is obviously experiencing joy. Babies who have been emotionally deprived do not respond to a smiling adult promptly. There is a lag before the baby's smile is elicited. The time lag in responding can be used as a test of the severity of the deprivation and as a measure of improvement when proper measures are taken.

The prompt change that took place when these babies were transferred to the care of a warm and attentive mother or mother substitute was striking. One such baby, who, at four months, weighed only as much as he had at birth; who looked like a tiny, wizened old man; and who looked as though he might tire and stop breathing at any moment was, nevertheless, sent home. When I visited him in his home 24 hours after discharge from the hospital I could hear him cooing in an adjoining room. From the day he reached home, he started to gain weight—on the same formula prescribed in the hospital—and continued to progress so that by the end of the first year his weight was in the normal range and his development was normal in every other respect.

There is good reason to believe that the basis for the symptoms of emotional deprivation is sensory deprivation. Depression has not been observed as a manifestation of sensory deprivation in experiments in adults. The experiments have necessarily been of much shorter duration than the clinical exposure of the babies to sensory deprivation. Moreover, sensory experience has a unique function in infants. It is the only way in which an emotional reaction can be initiated. Adults — even young children — can originate an emotional reaction by imagining exciting situations. It is hardly conceivable that this is possible during infancy. The infant is dependent entirely on his environment for originating an emotional reaction. We have hypothesized that the physiologic accompaniments of an emotional reaction — hormonal (epinephrine, for example), circulator, etc, are essential for the baby's existence.

Emotional deprivation is no longer the institutional scourge that it was not too many years ago. In 1949, in preparation for a paper on emotional deprivation, I visited an institution for the care of babies that once had the very high infant mortality prevalent during the early decades of the century. I was unable to find a single baby showing the clinical features of emotional deprivation. The hospital had a roster of almost 1,000 women volunteers who came and played with the babies. Moreover, the babies were not kept in the institution for prolonged periods.

Emotional deprivation is still seen occasionally in infants reared in the home by mothers who, for one reason or another, spend little time with their babies.[14]

I have spoken of emotional deprivation — or hospitalism — in the past. We have pretty well eliminated it as an institutional phenomenon in the United States and in many of the other developed countries. But it still occurs in some parts of the world. Infants are admitted to hospitals and are kept there after recovery, hoping for complete rehabilitation, because the homes are considered inadequate and convalescent homes are unavailable. Tragedy follows.

Depression is a response, commonly seen in young children starting at about six months, to separation from the mother. In many undeveloped countries, mothers, following the birth of a new baby, leave the older child to be looked after by relatives or friends, while she nurses the new one. What the effect of this separation is on the older child has, as far as I know, not been studied. That the nursing baby is relatively immune to kwashiorkor or protein deficiency disease and that it occurs after nursing is discontinued is well known. Are the psychologic effects of separation etiologically related to the development of kwashiorkor? I think it is well worth looking into.

Depression, referred to by Spitz[15] as anaclitic depression, is seen in infants, starting during the second six months of life following separation of the baby from the mother. Here the basis is different from that seen in young infants. As mentioned before, in young infants the symptoms are due to sensory deprivation. In the older infants, the depression stems from an awareness by the infant of the mother-child relationship. It is dependent on *intellectual* development and consequently is not seen in mentally defective infants. Bowlby[16] has written extensively on this type of early depression.

Again it seems to me, in visiting several undeveloped countries (most recently Central America), that mothers do not converse with their children nor do they play with them to any extent, and the children in hospitals look unhappy. Here, too, to what extent are psychologic factors important in the common everyday type of malnutrition rampant in most undeveloped societies?

Are we justified in attributing mood swings to infants? I think we are. Emotional manifestations — anger, fear, joy, even erotic emotion — can be recognized in the young infant after the first month or two of life. I have spoken about joy shown by the young infant. Fear and anger are shown early. Erotic reactions — orgasm — have been recognized in babies only a month or two old.[17-19] Mood differences have also been described in babies — friendliness or unfriendliness, apathy or animation, approach or withdrawal.[20] It seems definite that mood changes — among them depression — are experienced early in life.

I had the opportunity of observing a young boy who showed a severe degree of depression. This boy made repeated and serious suicidal attempts beginning at 3½ years.[21]

Henry was the oldest of three children. During pregnancy the mother had had a "kidney condition" and was "swollen." He was born at term without difficulty.

At five months he began to bang his head. This became worse with time, and he would strike his head against a hard object such as the floor or a stone wall whenever he was frustrated. The habit lasted until he was two years old. At this time he was described as aggressive, negativistic, bossy, quarrelsome, talkative, and overactive. At 4½ years his IQ score on the Goodenough Draw-a-Man test was 127.

The first suicidal attempt was made at 3½ years when Henry stepped out of a first-story window. Shortly thereafter he was found hanging by his arms from the fire escape. About this time he fell down a flight of stairs and bruised his head. He was also injured in a revolving door. At four years, after a severe beating, he said he was going to jump out of the window. He repeated this threat whenever he got angry. The parents' reply was to "go ahead."

He made numerous other attempts at self- destruction. At five years four months, while being taken to a play group in a bus, he would repeatedly leave the bus when it stopped, and rush out into the open road among the moving cars. When he saw an exceptionally large dog, he would put his hand into the dog's mouth. He would ride his bicycle in front of automobiles moving toward him. The kindergarten teacher reported that he tried to smother himself under a blanket. The camp director notified the mother that Henry was "out to kill himself." When cautioned that he would hurt himself, he said "I want to get hurt," and "I want to break a leg."

At 5½ years, he jumped out of a seventh-story window. He got up and tried to walk, but collapsed and was stuporous for five days. The small bones of one foot were broken. Recovery was complete. He was admitted to the Children's Psychiatric Division at Bellevue Hospital for study but was removed by his parents after 48 hours, before any conclusion about his psychiatric status was reached.

The mother was dull mentally and rather passive. Her sister characterized her as loving the child with "a love which is so intense it is abnormal." The father was foreign born and was described as dictatorial toward the children. He

had been previously married and divorced. He spanked the boy repeatedly. When Henry was two or three years old, his parents tied him in his crib because he tried to get out and leave the house. Henry was antagonistic toward his father and hated him. He was intensely and overtly jealous of his father's relationship with his mother. At the same time he seemed to feel guilty about his feelings and wanted to punish himself.

Henry indulged in all sorts of mischievous tricks, such as pulling off the tablecloth and strewing china and silver on the floor, throwing his father's lamb chop into the garbage pail, and emptying the saltcellar into his mother's coffee. When spanked, he would not cry, but would say "Give me more."

At 8½ years Henry had not voiced any more suicidal threats or made any more suicidal attempts. His behavior was still troublesome. He was described as "high strung, uncooperative, very disobedient." He had no interest in school, and his schoolwork was poor. His resentment toward his father continued.

At 13½ years he was still a "terrific" problem. He was just getting by in his school work, although he was a bright boy who should have done much better. He created disturbances in the classroom and seemed to enjoy flaunting authority. He was resentful towards his father, who now treated him gently and kindly. The father was outwardly calm and easygoing. Henry fought with his mother continuously. He took a dim view of life, always assuming a pessimistic attitude and predicting the worst.

Here then is a boy whose depression was already apparent at 3½ years and whose depression was so severe as to lead to a serious suicidal attempt at 5½ years.

The origin of the boy's depression is obscure. Neither of his parents showed this trait.

Depression, as part of the manic-depressive psychosis syndrome, is rare in children. According to a number of observers,[22,23] less than 0.5% of manic depressives have a depressive episode before the age of ten years. Isolated cases have been reported as early as four years. In children, only the depressive phase is seen.

Summarizing the clinical manifestations of depression in children, we may say that the characteristic mood change of sadness and unhappiness can usually be detected if looked for. It is often masked by aggressive behavior, social withdrawal, self-depreciation, deterioration in school work, and somatic symptoms — principally headache and abdominal pain.

Elation or euphoria, the opposite of depression, is much less common than depression. Is it, like depression, abnormal? Are happy-go-lucky people to be regarded with suspicion? Surely not all happy people are abnormal. But the persistently elated person requires a second look.

## Effects on Health

It is not generally appreciated that depression — or grieving — has a profound effect on general health, a fact which has been amply demonstrated. Both the morbidity and mortality are much higher in the bereaved, following the death of a near relative, than that in the general population.[24,25] Visits to physicians are much increased in widows in the first six months following the death of their husbands. This was found to be more striking in younger than in older widows.

In the first year of bereavement, the death rate of near relatives of persons who died was found to be seven times as great as in nonbereaved persons. Death was highest in the widowed group. The causes of death were miscellaneous — among them tuberculosis, syphilis, carcinoma, diabetes, and suicide. Presumably the grieving and the associated depression influences the way one reacts to a wide spectrum of diseases.

A striking example of the effect of acute grief on a bereaved animal was described by Engel[26] who was able to verify the incident personally. The affair concerns a pair of llamas that had been inseparable companions in the zoo for 13 years. The llamas escaped during a snow storm. The male became unmanageable and was shot and killed in full view of the female. She at first stood motionless; then she approached his prostrate form, sank to her knees, and silently rested her head on the dead body. In 15 minutes she was dead.

The effect of depression on the reaction to disease has been extensively studied by Engel.[26] He has described a state which he refers to as the giving-up, given-up syndrome. He has observed this state, the core of which seems to be depression, preceding an illness in 70% to 80% of adult patients. The complex is neither a coincidence nor a consequence of the illness; it plays a significant role in modifying the way the patient reacts to disease.

Engel described five characteristics of the giving-up, given-up syndrome: 1) a sense of psychologic impotence, a feeling of not being able to cope with the environment, a feeling of helplessness and hopelessness; 2) loss of self-esteem; 3) loss of gratification or sense of achievement from relationships or completed tasks; 4) loss of a sense of continuity between the past, present and future; and 5) a reactivation of memories of former periods of giving up.

The psychological state of giving-up, given-up is transient, sometimes intermittent. It is part of the experience of all of us. The complex is only an exaggeration of a normal psychologic phenomenon. According to Engel, disease supervenes when prompt resolution of psychologic conflict is impossible and one finds oneself alternating between giving up and struggling to find a solution.

Engel proposes that, during the giving-up, given-up state, the biologic economy of the organism is altered and its ability to deal with a certain potentially pathologic process is reduced permitting disease to develop; provided, of course, that the disease predisposition was already present.

A subtle way in which depression may cause somatic disease has been described by Levine[27] of the Department of Psychiatry, Harvard Medical School. He suggests a causal relationship between depression and spinal disc protrusion. He attributes swelling of the disc to alterations in cortico-steroid metabolism with, as a result, intracellular sodium retention and increased water retention. The idea may seem far-fetched, but there are some observations in animals to back it up.

There are no data on the effect of grief or depression on the health of children, except insofar as somatic complaints are present. I doubt that the dire effects of depression on the death rate in adults are nearly as marked in children.

## Chemical Changes

The notion that chemical changes are responsible for depression is an ancient one. The old term, widely used to describe depression (melancholia), means dark bile. A number of chemical changes have been described in depressed individuals.

A definite relationship between the mental state and the fasting serum lipid levels has been reported by Hullin and Court.[28] The fasting serum level of triglycerides, sterols, sterol esters, and phospholipids was found to be greater during the depression state of manic depressive psychosis than during the manic state. A rapid fall in the serum lipids accompanied spontaneous recovery from depression.

Patients with high depression inventory scores were reported to have low serum folate concentrations. Some also showed low serum vitamin B-12 values.[29]

The total resting plasma catacholamine concentration—epinehrine and nonepinephrine — has been found to be elevated in depressed patients.[30] The catacholamines are also increased in the brain, spinal fluid, and urine.

There is great interest in the relation of the cerebral monoamines to depression.[31] Neurochemical, histochemical, and neuropharmacologic studies show that the monamines are located in specific clusters of neurons. Their distribution has been partially mapped. Furthermore, the monamines in peripheral synapses as well as in the brain are significantly altered by most of the procedures that are effective in altering mood in man; eg, electro-convulsive therapy and drugs, particularly the antidepressant drugs like the tricyclic compounds and monamine oxidase inhibitors.

The significance of the chemical changes in depressed patients is not clear—whether they are causative or whether they, in some way, result from a change in the behavior of the depressed individual. Whatever their basis, they do mean that depression is associated with definite, measurable somatic changes.

## Etiology

The types of depression may be divided into four groups: 1) depression as a reaction to adverse conditions — an unhappy home situation, loss of a loved one, failure to achieve scholastically or in athletics, drugs, and the like; 2) an exaggerated and unduly prolonged response to adverse circumstances; 3) endogenous depression, not preceded by unfavorable life experience; and 4) depression as part of the manic-depressive psychosis syndrome.

A transient adversity, like loss of a near and dear one, or failure to do as well as hoped for at school or in athletics may lead to a brief period of depression, but prolonged depression is usually the reaction to a persistently unfavorable situation in the home — parental incompatibility and quarreling, a critical, hostile attitude of the parents, rejection, and the like.

The basis may also be a developmental deviation in the child. For example, the child with developmental dyslexia may be subjected to critical, intolerant parents who do not understand his problem or who are unwilling or unable to accept it. That such a child will suffer is self-evident. But even when the parents understand that developmental dyslexia is an inborn deviation for which the child is not responsible, a bright, sensitive child, aware of his scholastic shortcomings, will be unhappy, and will often react with depression. Similarly, the child with developmental hyperactivity is often aware of his poor motor control and its adverse effects on his parents and others. As a result, depression is not uncommon.

Endogenous depression, in which no reason

for the mood change is evident, is seen in children, just as it is seen later on during adolescence and adulthood. The frequency with which a family history is obtained suggests the possibility that genetic factors may be influential etiologically. Further evidence favoring this view is the early age at which mood differences are recognizable.

The influence of climate on mood is an interesting one, principally because it seems to influence the day-to-day variations in mood which affect each and every one of us. Little attention has been given to this subject in modern literature. The best evidence we have that climate does influence mood is shown by the variations in the suicide rate by season of the year. The suicide rate is highest during the spring months — April to June — which we ordinarily think of as the joyful months, and lowest during the winter months. The seasonal variation is well marked; in some years the difference between the highest rate and the lowest amounts to as much as 35%.

It might be supposed that the high rate in the spring among adolescents is related to examination time; and the low rate during the winter season has to do with the holiday festivities of Christmas and New Year. However, the high suicide rate during the spring months is not restricted to adolescents. Moreover, the seasonal variation, characteristic of countries in the Northern Hemisphere, is also seen in Australia. Down under, in the Southern Hemisphere, there is a tendency for the low rates to occur in May and June, the winter months there, and the high rates in October to December, the spring months. The seasonal variation is not as striking in Australia as in the Northern Hemisphere. This is to be expected, since the seasonal climatic variations are not as marked as here.

Attempts at isolating the climate element responsible for the seasonal variation in suicide have been unsuccessful.[32] It has not been possible to relate the suicide rate to temperature, humidity, or the temperature-humidity index.

I believe that weather influences mood, though the evidence is impressionistic rather than factual. On certain days, or rather certain mornings, people seem cheerful and ready with a smile and a friendly greeting; at other times, morning greetings are formal or even gruff.

I once met a young woman who had been hostess at a restaurant during breakfast time. She remarked that, on certain days, the restaurant guests seemed friendly, pleasant and cheerful, on others unfriendly and glum. My first reaction: "Were the low days rainy days?" To which her answer was "No." In fact, according to my own experience, a light drizzle is exhilarating. Known to be exhilarating, too, is the reaction to the low atmospheric oxygen tension of high altitudes. Some years ago I felt greatly exhilarated on a visit to Arroya in Peru, which is at an altitude of 12,000 feet, at which the oxygen tension in the air is reduced to 70%.

In the older German literature — during the early decades of this century — much attention was given to the depressing influence of Föhnwetter, accompanied by fatigability, apathy, drowsiness, and headache. It refers to warm, oppressive breezes from the Swiss Alps during the spring months in the Austrian Tyrol. In other areas, notably Libya, a similar climatological phenomenon is referred to as sirocco. The North Italians speak of "bora," the French of "mistral," and here in the United States in the Rocky Mountain area we have the "chinook."

### In Adolescents

Depression in adolescents is well recognized and is not infrequent. The causes are much the same as in adults, plus those matters of special concern at this developmental stage — loss of a near and dear relative or friend, a scholastic reverse, disappointment in love, unpopularity. Failure to live up to one's own scholastic aspirations is more often a cause of depression than scholastic failure. An adverse home situation is not as important as a cause of depression in adolescents as it is in children, but it is a prominent consideration. Critical parents, parents uninterested in their child's progress in work or study, parents who are critical of the value of a college training, financial reverses at home — any of these may lead to depression.

Concern about one's sex role is a not infrequent cause. Currently, when freedom of sex activity is accepted at a relatively early age many a youth, who happens to be a later maturer, finds that he is not developmentally ready to behave as many of his age peers do and go all out sexually. This may lead the youth to feel that he is, in some ways, inadequate or sexually deviant. Concern about homosexuality is not uncommon.

Illness — diabetes, for example — may be a cause. A principal concern here is the effect on marriage and on transmitting the disease to the children.

Endogenous depression — depression unrelated to life experience — occurs in adolescents, probably rather frequently.

In the United States the incidence of suicide begins to rise at 15 years of age.[33] Between 15 and 19 years it is the fourth most frequent cause

of death, being exceeded only by motor vehicle accidents, malignant disease, and drowning. Suicide in the adolescent is more frequent in the better educated groups. At colleges it is the second most frequent cause of death, after motor vehicle accidents.

The current widespread use of drugs does not seem to have affected the suicide rate.

Suicide attempts are very frequent, especially in adolescent girls. According to a study made in New York City,[34] they are particularly common in Puerto Rican girls. There were over 100 suicidal attempts to a completed suicide. At Bellevue Hospital we have come to speak of suicidal "gestures" rather than "attempts." The basis is usually a disagreement with the parents or the lover — not depression. It is an impulsive acting out.

Although suicide and serious suicidal attempts in the adolescent are usually on the basis of depression, there is a sizable group which is not. I refer to the hanging syndrome in adolescent males described by Stearns.[35] This group is made up of young adolescent males who commit suicide by hanging. They are normal-behaving boys who are getting along all right, seemingly content, often popular. They cross-dress, ie, they don one or more articles of female clothing, they tie themselves up, and they surround themselves with pictures of alluring females. It is suspected that the boys go through these ceremonials to get a sex thrill and do not mean to commit suicide. A case of this sort has been reported, where the boy was cut down before suicide was completed.[36] I interviewed a man in his 30s who said he used to go through the hanging ritual as a preliminary to masturbation.

However, the sex thrill theory does not explain the predilection of male adolescents for hanging as the method of choice for committing suicide. Sex differences in physiology and in behavior do not necessarily have to do with the sex hormones. At birth there are striking differences in mortality — male mortality exceeds female by about 50% — and, in newborns, well-defined differences in behavior are already discernible.

## Treatment

The first step in the treatment of a child with depression is a study of the family, since an adverse home situation is a frequent cause of the disorder. In some families the adverse home situation is due to well-intentioned errors on the part of the parents and is readily correctible. In others, the family situation is more complicated and the case may have to be referred for proper handling to a psychiatrist or a social agency.

A developmental deviation in the child should be considered. The basis for the child's unhappiness may be developmental dyslexia and undue pressure at home for better school work. However, as mentioned before, even in homes where dyslexia is handled with understanding, a bright child, aware of his inability to compete scholastically with his peers, often reacts with depression. An explanation to the parents, in the child's presence, of the nature of the deviation, emphasizing that dyslexia may be present in individuals with high IQ and mentioning the names of dyslexic individuals who have attained eminence will help to relieve the child's unhappiness.

Some children with developmental hyperactivity come to appreciate the adverse reaction of the parents to their behavior and are concerned. Drug treatment of the hyperactivity is indicated, together with an explanation to the parents of the nature of the disorder, emphasizing that it is not willful misbehavior.

Success has been reported by some workers with antidepressant drugs (imipramine and amitryptyline).[37,38] In general, before beginning drug therapy, a study of the home situation, with corrective suggestions, should be made. There are times, however, where drug treatment may be introduced early. A favorable response of the child, an improvement in his behavior, may modify adverse parental attitudes and, at the same time, make them more amenable to the suggestions of the physician.

Medication is given in gradually increasing amounts, up to 100 mg a day for a 12-year-old child. Medication is given in two or three divided doses. It is continued for a month or more after improvement has taken place and then gradually tapered off.

Severely depressed children who fail to respond to treatment may require removal from the family for a time.

In summary, depression is an important syndrome in children. It should be considered as a diagnostic category, not only when the characteristic mood changes are prominent, but when the symptoms are masked by other behavioral changes or by somatic symptoms, notably headache and stomach ache. In most cases, the outcome is favorable by correction of unfavorable circumstances in the home, by attention to developmental deviations in the child, and by the use of antidepression medication.

### References

A complete listing of the 38 references used with this article may be secured from the author.

# PSYCHOLOGICAL FACTORS AFFECTING ROUTINE MEDICAL CARE

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Separation of mind and body at the conceptual level has undoubtedly served many useful purposes. Such a separation, however, causes a great deal of confusion and frustration at the clinical level — both to physicians and to their patients. The dilemma is that this dualism does not correspond well to the realities of the clinical practice of medicine. While the problem is currently being recognized in the movement towards Comprehensive Medicine, reductionistic ways of thinking are so deeply entrenched in modern medicine that rectification is by no means a simple endeavor. The danger is that, to many, Comprehensive Medicine implies the mere addition of various tangential psychosocial dimensions to the traditional patterns of medical thinking.

Truly comprehensive Medicine implies more. In it, psychosocial factors are not merely an extension to be tacked on after the real work is done, but are an integral part of that real work of the practice of Medicine. Consideration of factors relevant to the patient as well as factors relevant to his disease is no mere indulgence; it is a necessary and often extremely relevant part of the physician's traditional task of providing maximal and sustained health to his patients. The meaning of an illness to the patient and his understanding of its etiology, pathology, and prognosis tend to be extremely personal and often differs remarkably from the ideas of his physician.

How the patient responds to his symptoms and to necessary medical interventions will depend on his understanding of their significance. Many of the patient's fears may not be on a fully rational basis and some of his concerns may not fully enter his awareness. Yet even a beginning understanding of some of these patient factors often removes a good deal of the seeming mystery that surrounds the vagaries that occur during a given patient's course of illness. Patient variables that usually merit consideration include:

1) The patient's personality, previous level of functioning, and significant aspects of his life history.

2) The current social and economic situation of the patient and his family. This includes his role within his family and the characteristics of his physical environment.

3) The subjective meaning of the illness to the patient and his family and its nature and characteristics as they perceive it.

4) The time at which the illness occurred in the patient's life and its impact on him and his family in regard to his future level of functioning.

While many illnesses can be caused or aggravated by stress, illness itself represents one of the main stresses of civilized societies. Illness sufficiently severe to warrant consulting a physician often mobilizes specters of death, incapacitation, and helplessness. Patients resent their illnesses and at times displace this resentment to their physicians. Some feel so threatened that they resort to mental mechanisms such as denial to obtain comfort.

The degree of danger the patient perceives in his situation is related to the severity of his symptoms, his knowledge of the illness, and his previous life experience. Such fear may show itself as any one of a number of physiological manifestations of anxiety, such as tachycardia, paresthesia, syncope, or hyperventilation; these may serve to complicate the presenting picture.

Patients may react to the threatened loss of function or security with an episode of depression which may include symptoms of insomnia, anorexia, impotence, fatigue, and constipation. In his diagnostic workup, the physician must determine which symptoms are primary and which are secondary, but in his management of the patient both sets of symptoms usually need be taken into consideration. In hospitalized patients, such additional psychological stresses as separation from family and customary environment, enforced dependency, and an increased sense of vulnerability may cause reactions which obscure the clinical picture.

Similar physiological symptoms can occur in response to environmental stresses, and in some neurotic individuals in response to threats which have little basis in reality. Physicians at times respond angrily to such patients telling them erroneously, usually after a number of diagnostic tests have been performed to rule out organic pathology, that nothing is wrong. There is another group of neurotic patients that often cause

the physician consternation because of their resistance to his efforts to get them well. For such patients, the disadvantages of being ill are outweighed by its advantages to them. Illness may meet unconscious needs for punishment, may sanction the fulfillment of dependency needs which cannot otherwise be met, may remove the patient from a threatening social stress, or may provide a method of resolving inner conflicts. In such patients, recognition of the primary problem and treatment directed towards it rather than towards the medical complaints, can often result in an unexpected "cure."

In chronic illnesses particularly, the active cooperation of the patient is often essential if optimal functioning is to be obtained. Patients may tend to treat their physicians as authority figures, are afraid of their power, and are somewhat distrustful of their good intentions. Rebelliousness and passive helplessness can result. The physician can learn to recognize such tendencies and avoid them by acting in a less authoritarian manner, by listening to his patient and taking his point of view into consideration, and by early sharing with him of some of the responsibility for outcome. The physician that does this will have fewer diabetics who don't take their insulin, fewer patients with myocardial infarction signing out of the hospital, less unnecessary invalidism.

In summary, major factors which determine how a given patient will cope with his illness and respond to it include:

1) The manner in which the patient has previously dealt with stress.

2) His current social situation including the response of his family.

3) Previous experience of illness and reactions.

4) Quality of the doctor-patient relationship and management of the illness by the doctor and other medical personnel.

5) Both the doctor's and the patient's expectations of outcome.

The following brief case is offered to illustrate some of these principles.

A 43-year-old married Negro female, mother of three, presented complaining of weakness, myalgia, headaches, and nausea without vomiting. Initially, she was seen in the Emergency Room where she appeared to be in no acute distress. Work up was negative but the patient was referred to the General Medical Clinic for further evaluation. The physical examination was again negative except for a questionable "minimally enlarged thyroid gland." CBC, UA, PBI, T4 were within normal limits. Deep tendon reflexes were 3+ and a neurology consultation showed no abnormal findings.

During the next two months, the patient presented four times complaining of worsening of symptoms with increasing loss of appetite. No constipation, overt depression, or sleep disturbances were present.

Three months after the initial visit, the patient had lost 15 pounds and, according to her husband, was so weak that she could not maintain her daily activities. At this point, she was seen in consultation by a senior medical consultant who took a careful social history and obtained the following data:

1) Patient's symptoms developed one week after finding out her 16-year-old daughter was pregnant.

2) Patient had not volunteered the information to previous doctors because she was ashamed.

3) Patient was afraid she might physically harm her daughter if she "ever let my anger go."

4) Her nausea was described at this time as "like when I was pregnant."

5) The myalgia made motoric movement difficult for the patient.

At this point, it was suggested that the family, including the daughter, be seen by the Internist in conjunction with a Psychiatrist. Three family conferences were held. During these sessions, it became clear that the daughter felt extremely guilty but was unable to express her feeling to her parents. The mother had also born her first child out of wedlock, and her guilt feelings were increased by her daughter's pregnancy. The mother had displaced her own guilt to her daughter and thought of hurting her physically because "that's what my parents wanted to do to me."

The mother's complaints began to diminish markedly after the first session and were completely gone within one week of the last visit. A six-month follow up revealed no recurrence.

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# ESTIMATING EDUCATIONAL CASUALTY FROM THE 1964 RUBELLA EPIDEMIC IN MARYLAND

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The first effects of the nationwide rubella epidemic were recorded in the State of Maryland during the early months of 1964. Since then, much has been written about the immediate and long-range consequences of this epidemic.

Although some speculations have been made, the literature to date contains little documentation of the residual effects of the epidemic, especially in regard to the educational potential of the cohort of children who survived the neonatal period and were not institutionalized because of severe retardation. This group of children, currently becoming the concern of the special educator and allied health personnel, is the subject of this paper.*

Because the rubella virus must pass from an infectious source through a gravid woman to a fetus in some stage of development, a complex variety of clinical manifestations of congenital disease may result. Therefore, operating definitions for this study are as follows:

**Congenital rubella sequellae:** a nonspecific term for children with any organ system defect (including death) due to congenital rubella infection.

**Congenital rubella syndrome:** children who experienced rubella virus infection in utero, proven by culture and antibody production, resulting in severe and (usually) multiple defects of various organ systems—low birth weight, central nervous system damage, congenital heart disease, hepatosplenomegaly, etc—many of which persist into later childhood.

** The first of the children affected by the epidemic should have begun to enter primary school by the fall of 1970, the majority in 1971, and the last in 1972.*

**Probable congenital rubella:** children with multiple defects of various organ systems, similar to those associated with congenital rubella syndrome, but diagnosed retrospectively after infancy, with or without serum HI antibodies.

**Possible rubella sequellae:** children with organ system defects that could have been produced by congenital rubella infection—low birth weight and subsequent failure to thrive, small head circumference, subnormal intelligence, hearing loss—usually isolated in occurrence and relatively mild or inapparent in expression.

A review of the rubella literature since 1965 revealed convincing documentation of the damaging effects of the virus on developing fetal organ systems, as typified by the reports of Cooper[1] and Sever.[2] However, projections of the nature and prevalence of residual effects left much to be desired, and actual examples of mass programs for retrospective diagnosis were practically nonexistent.

In 1965 Plotkin,[3] referring to data from the work of Sever[2] and Schiff,[4] estimated the prevalence of children with congenital rubella sequellae to be anywhere from 0.3% to 4.0% in pregnancies occurring during the epidemic period of risk. Horstmann[5] also gave an estimate of 0.3%. The official US Government nationwide projection has been subsequently set at 1.0%, based on data from many sources.[6] (It is unfortunate from the viewpoint of public health and education planners that these projected prevalence rates were not further refined as to severity and/or expression of disease, as was necessary for the purposes of this survey).

Particular concern was caused in Maryland

by Hardy's finding of "evidence compatible with congenital rubella infection" in approximately 10% of the pregnancies under prospective surveillance in the Collaborative Perinatal Research Study at The Johns Hopkins Hospital.[7] These cases were diagnosed by both clinical and laboratory means. They exhibited the expected range of abnormalities including hearing defects and mental subnormality in excess of 50% where maternal infection occurred in the first trimester. There were less severe, less characteristic findings after second and third trimester rubella.

There were nearly 100,000 live births in Maryland in 1964 and 1965 that could have been affected by the epidemic. State and county public health and education authorities reasoned that if the rate of congenital rubella sequellae were anywhere near Schiff's 4.0% or Hardy's 10.0% projection the fetal wastage, infant mortality, and residual development and educational casualty could assume formidable proportions. As a result, surveys and early detection programs were urged to estimate coming health and education needs.[7]

Several early pilot and promotional programs in the state failed to turn up significant numbers of previously unidentified children with congenital rubella sequellae.* Taking a more sophisticated approach. Weinberger and coworkers[8] were able to diagnose retrospectively only four cases of probable congenital rubella (.02% of the 16,700 children at risk) in populous Montgomery County. However, both Hardy[9] and Weinberger[8] postulated that **many children of preschool age with congenital rubella sequellae remained at large in the general population.**

Because of the concern that several thousand such children, as yet undiscovered, might overwhelm the special education facilities of the state in 1970, a cooperative epidemiologic survey to estimate their numbers and characteristics in a more representative population was begun in the summer of 1968. Frederick County was chosen for study because of its demographic characteristics and active case reporting which had documented both the onset and height of the epidemic.

The objectives of this survey were:

1) to estimate the prevalence of **congenital rubella syndrome** and **probable congenital rubella** in a sample of living, noninstitutionalized children who were at differential risk for contracting congenital rubella infection during the 1964 epidemic, and who were currently residing in a typical nonmetropolitan county in the State of Maryland;

2) to assess the impact of the epidemic on the survey population and to lend support to the diagnostic validity of the two categories in 1) by examining the secular trends of selected **possible rubella sequellae** in the same sample;

3) to determine if further large-scale, statewide screening efforts, based on this pilot survey, would be useful for early detection and remedial intervention; and

4) to determine if health and educational authorities should prepare for significant numbers of defective children, in excess of those already known, who would enter the primary schools of the state in 1970 and subsequent years.

## Materials and Methods

Frederick County had a varied topography including farm lands, mountainous areas, small and large towns, and a city with suburbs. The population was 94% white, 6% black, and included representatives of every socioeconomic strata. The county was divided into 26 elementary school districts.

According to the epidemic curve for rubella constructed for Frederick County and Baltimore City (Fig 1), children born prior to and during the first quarter of 1964 should have virtually completed their intra-uterine life before the height of the epidemic and therefore be at little or no risk for congenital defects from the disease. However, those born in the succeeding three quarters of the same year would be at progressively increasing risk for this occurrence. The children born during the last quarter would be at maximum risk because of exposure during the first trimester. Therefore, a sample including children from each quarter of 1964 would afford both comparison (low risk) and study (high risk) groups.

The sample consisted of every known child born during the year 1964 in each of seven elementary school districts, selected to insure representation of the major topographic and demographic variables described here. The children would range from 3½ to 4½ years of age. Since the major goal of the study was to estimate educational casualty, only those children who would be expected to attend elementary school at the usual age were sought, ie, the deceased and institutionalized were excluded. A master list of 647 children was subsequently compiled from the following sources: preschool "census"

* *It is probably significant that affluent Baltimore County, known for its special education facilities, experienced no increase in yield from its 1968 hearing screening program (testing the birth cohort of 1964) over that of previous years.*

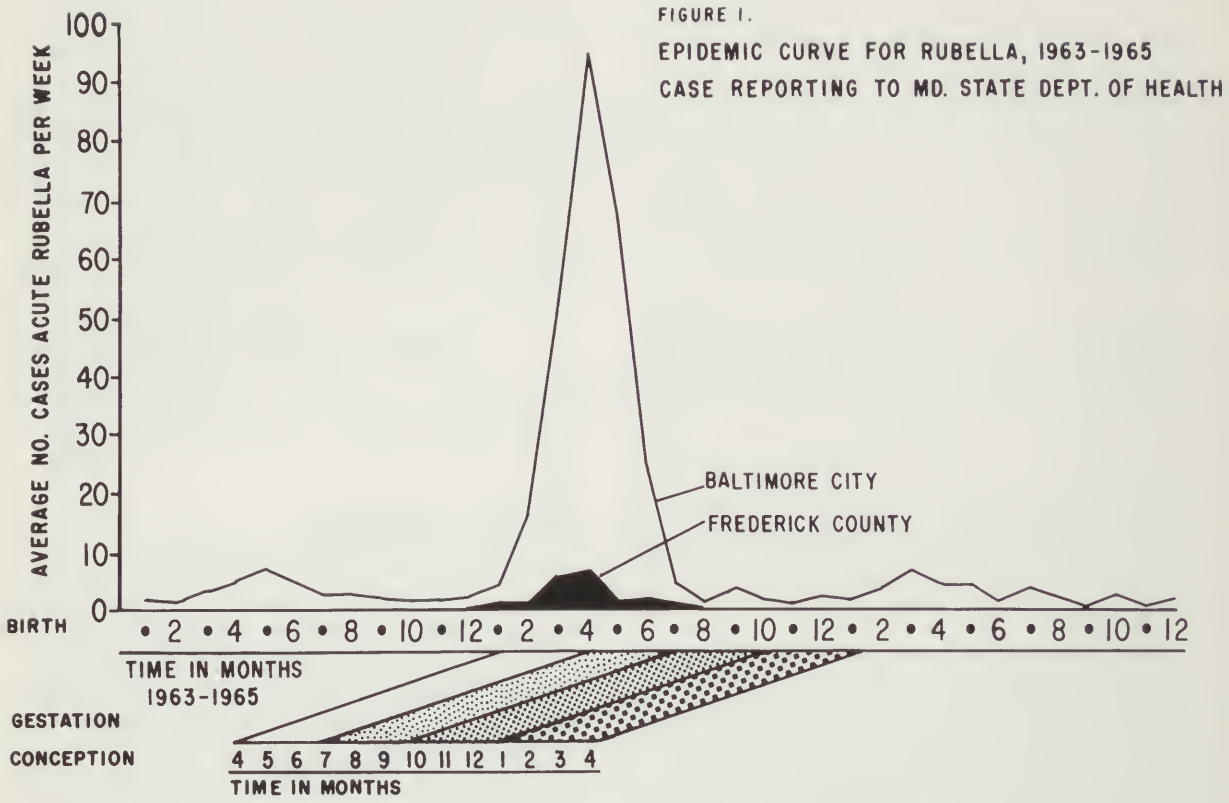



FIGURE 1.
EPIDEMIC CURVE FOR RUBELLA, 1963-1965
CASE REPORTING TO MD. STATE DEPT. OF HEALTH

**Table 1: Screening Criteria for Diagnostic Evaluation of Children Suspected of Having Congenital Rubella Sequellae; Numbers Referred in Each Group**

| Group I (N=5) | Group II (N=2) | Group III (N=10) |
|---|---|---|
| History of clinically identified rubella in the mother in any trimester of pregnancy | History of definite maternal exposure to rubella in any trimester of pregnancy | No clinical identification of, or exposure to, rubella |
| Failure of one or more screening areas specific for rubella | Failure of two or more screening areas specific for rubella | Failure of three or more screening areas specific for rubella |

**Table 2: Screening Test Failures By Test**

| Children Failing Screening Tests* | Number | Percent |
|---|---|---|
| Head circumference 2nd percentile | 22 | 3.7 |
| 20/40 or worse, either eye, or untestable | 97 | 16.4 |
| Failed to hear any one sweepcheck tone | 166 | 28.1 |
| Abnormal performance on the DDST | 117 | 19.8 |

*Categories not exclusive, N=590

records kept by the seven elementary schools, county birth records, county welfare records, nursery school records, newspaper publicity, knowledge of the county public health nurses, and knowledge of the parents of those already located.

A vigorous recruitment effort brought 590 children, 91.2% of the sample list, to the screening stations located in elementary schools. Information from all other possible sources (birth records, records of private physicians, direct questioning of parents by phone) concerning the 8.8% of the sample refusing screening revealed that none were known to have multiple congenital defects except one child, whose exact condition could not be determined without further examination.

Each child received a five-part battery of screening tests specifically chosen to detect the more common sequellae of congenital rubella during the late preschool years (especially those which would require special health and educational services):

| Screening Tests: | Rubella Sequellae: |
|---|---|
| 1) Height, weight, and head circumference | 1) Failure to thrive |
| 2) Vision screening, modified Snellen method* | 2) Cataracts, microphthalmus, glaucoma, myopia |
| 3) Pure-tone audiometry | 3) Sensory-neural hearing loss |
| 4) Denver Developmental Screening Test[11] | 4) Developmental subnormality |
| 5) Physical screening examination | 5) Congenital heart disease, cerebral palsy, other congenital defects |

** Developed by the Maryland Society for the Prevention of Blindness and subsequently described by Patz and Hoover.[10]*

A child was considered to have failed a screening test if he:

1) had a head circumference falling below the second percentile, after Nellhaus,[12]
2) was unable to read better than the 20/40 symbol correctly four out of six times on the Snellen card in either eye during the first screening,
3) failed to hear any one of the frequencies in the pure-tone audiometric test,
4) had abnormal performance on the Denver Developmental Screening Test, or
5) had any of the characteristic physical stigmata of congenital rubella.

In order to estimate the prevalence of congenital rubella syndrome and probable congenital rubella in the survey sample, all children having some combination of maternal rubella infection and screening failure consistent with the criteria set forth in Table 1 were referred to The Child Growth and Development Center at The Johns Hopkins Hospital for definitive diagnostic evaluation by Hardy and coworkers, who had had extensive clinical experience with the disease.[9]

In addition to those suspected of having congenital rubella sequellae, children who failed the hearing screening were referred for otologic and audiologic examinations, and children who had questionable or abnormal performance on the Denver Developmental Screening Test, plus a 70% sample of those with normal performance, were followed up with the Stanford-Binet Test of Intelligence.[13] The purpose of collecting these data was to evaluate the field performance of the audiometric and developmental screening tests and to lend weight to the examination of the secular trends of the selected possible rubella sequellae.*

** The Denver Developmental Screening Test was subsequently found to have a sensitivity of .79 for detecting low intelligence and the pure-tone audiometry an estimated sensitivity of .74 for detecting hearing loss.*

## Results

Approximately 40% of the children failed one or more of the tests in the screening battery. The numbers of failures according to these criteria are summarized in Table 2 (the fact that certain children failed more than one test is not reflected in this tabulation).

According to the criteria set forth in "Materials and Methods," 17 children were selected for further study—five in Category I, two in Category II, and ten in Category III (Table 1). Twelve of the 17 children were permitted by their parents to undergo extensive diagnostic evaluation including pediatric physical examination, IQ testing, hearing and speech evaluation, cardiologic evaluation, and serum antibody determination (mother and child). Six of these 12 were clinically diagnosed as having probable congenital rubella. One other child, No. 2, had been known to Hardy since birth as a proven case of congenital rubella syndrome. The diagnostic profiles of these children are summarized in Table 3. The paucity of rubella HI antibody in the cases of probable congenital rubella is not considered a deterrent to retrospective diagnosis since many children with congenital rubella syndrome proven at birth have been found to lose significant amounts of antibody by the third or fourth year of life.[8,14,15] This is exemplified by the dramatic fall in the antibody titer of child No. 2.

If the child known to have congenital rubella syndrome and the six children with probable congenital rubella are lumped together as "congenital rubella cases," as shown in Table 4, it is seen that two were born in the second quarter of 1964, two in the third, and three in the fourth, giving prevalence rates of 1.2% for the whole year and 1.8% for the three quarters of greatest risk (exposure to infection during the third, second, and first trimesters, $N = 400$). The secular trend of the percent of children diagnosed as "congenital rubella cases" was not significant.

Thirty-six of the 590 children had birth weights less than 2,500 grams, and 22 children had a head circumference falling below the second percentile. Of the 295 children receiving the Stanford-Binet, 24 were found to have an IQ less than 84, and 136 were found to have an IQ less than 100. Of the 123 children receiving otologic and audiologic examination, 13 were found to have conductive hearing loss, two were found to have sensory-neural hearing loss, and five were untestable. The secular trends of the rates of these possible rubella sequellae are also

Table 3: Summary of the Clinical Findings of Seven Children Diagnosed as "Congenital Rubella Cases," The Child Growth and Development Center, The Johns Hopkins Hospital

| Child No. | Maternal Rubella During Pregnancy | Maternal HI Antibody | Child's HI Antibody | IQ | Hearing | Percentile+ Ht | Wt | Head | Hyper-activity | Other Physical Findings |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | no | 1:64 | <1:4 | 66 | normal | 10 | 3 | 3 | no | — |
| 2 | 5 wks | 1:2048 | 1.8* | 96 | profound loss | 3 | 3 | 3 | yes | — |
| 3 | 4 mos | 1:128 | <1:4 | 70 | mild loss | 75 | 50 | 10 | no | — |
| 4 | 4 mos | 1:64 | <1:4 | 88 | untestable | 50 | 75 | 90 | yes | — |
| 5 | 5 mos | 1:64 | <1:4 | 82 | normal | 10 | 25 | 50 | yes | — |
| 6 | no | refused | <1:4 | 75 | normal | 50 | 50 | 50 | no | Peripheral pulmonic stenosis; Misrophthalmus |
| 7 | no | 1:256 | <1:4 | 50 | untestable | 3 | 3 | 3 | no | Spastic diplegia |

* This child's HI antibody was 1:2048 at 26 mos., 1:32 at 40 mos., and 1.8 at 44 mos. (see text).
+ After Stuart.

Table 4: Trends in the Rates (%) of "Congenital Rubella Cases" and Selected Possible Rubella Sequellae for the Four Quarters of 1964

| | Comparison Group, N=273 | | Study Group, N=258 | | | | |
|---|---|---|---|---|---|---|---|
| Quarter of Birth, 1964 | 1 | 2 | 3 | 4 | Total* | $X^2$ | Sig. of Trend, |
| No. in Sample | 131 | 142 | 131 | 127 | 590 | (1 df) | $P < .05$ |
| "Congenital Rubella Cases" | — | 1.4 | 1.5 | 2.4 | 1.2 | 1.50 | N.S. |
| Low Birth Weight | 4.6 | 5.6 | 3.8 | 8.7 | 6.1 | 0.21 | N.S. |
| Small Head Circumference | 6.1 | 4.9 | 0.8 | 2.4 | 3.7 | 6.43 | Sig. |
| Subnormal Intelligence | | | | | | | |
| IQ < 84 | 5.3 | 5.6 | 3.0 | 1.6 | 4.1 | 0.03 | N.S. |
| IQ < 100 | 30.5 | 21.8 | 19.1 | 19.7 | 23.1 | 3.40 | N.S. |
| Hearing Loss | 0.8 | 2.8 | 0.8 | 4.7 | 2.2 | 0.48 | N.S. |

*Includes 57 children in the last quarter of 1963 and 2 children in the first quarter of 1965.

shown in Table 4. The rates of the first two quarters of 1964 (comparison group, N = 273) were compared to those of the last two (study group, N = 258) by means of the chi-square test. Although there were slight upward trends in the rates of low birth weight and hearing loss, neither was significant. Small head circumference and subnormal intelligence actually showed downward trends, the former being significant at the .02 level.

## Discussion

The retrospective diagnosis of children with congenital rubella sequellae in the later preschool years is complicated by cessation of virus excretion, declining or disappearing antibody titers, lack of high correlation between virus isolation and expressivity of defects, and possible confusion with other clinical syndromes. Thus any claim that a given set of organ system defects in a child is the result of congenital rubella infection must be either carefully documented or supported by other evidence.

A closer examination of the seven "congenital rubella cases" in Table 3 is therefore warranted. The one case of proven congenital rubella syndrome in the study sample was documented in infancy by virus isolation, typical antibody reaction in both mother and child, and a characteristic set of multiple organ system defects. On the other hand, the diagnosis of probable congenital rubella in the other six children was necessarily speculative, as earlier defined. In lieu of neonatal virus isolation and more definitive antibody data, it cannot be assumed that these defects were caused by rubella virus infection. The case for classifying these six children

as victims of congenital rubella is further weakened by the lack of statistically significant secular trends of possible rubella sequellae in the study sample.

The strongest statement that can be made about the effect of the rubella epidemic on the survey sample is that 1.8% of those at risk (N = 400) had defects compatible with, but not proven to be, congenital rubella sequellae. This was substantially less than the 10.0% projected by Hardy but almost double the official 1.0% nationwide projection. However, the one case of proven congenital rubella syndrome represented only 0.3% of the children at risk—close to the original crude estimate of Horstmann and the lower figure of Plotkin.

The multiphasic screening battery used in this study uncovered a significant amount of developmental pathology from a presumably well preschool population (Table 2). This could be viewed as a worthwhile activity for a school health service, provided that facilities exist to complete the necessary follow-up diagnostic and remedial procedures. However, since there was considerable doubt that the pathology found was due in large part to congenital rubella, it could not be recommended that further large-scale, state-wide screening efforts be employed on an emergency basis. From the perspective of the special education administrator, the most pessimistic prevalence estimate of 1.8% would mean that one child handicapped by rubella could be expected to occur in every two first grade classes of 30, while the most optimistic estimate of 0.3% would yield only one for every 11 classes.

There are several plausible explanations for the discrepancy between the projection of Schiff and Hardy (4.0-10.0%) and the findings of this survey (0.3-1.8%). Hardy's projection was an **incidence** figure. It included those with documented fetal infection plus some acute or potentially chronic expression of the disease in early infancy. Her denominator was an indigent, inner-city service population. In contrast, this survey was designed to estimate the **prevalence** of the chronic sequellae of congenital rubella in a nouinstitutionalized sample of late preschool age children drawn from a wide range of geographic and socioeconomic groups. In addition to these methodological differences, any cohort of children subjected to a rubella epidemic in fetal life would be expected to have its numbers significantly reduced by early death or institutionalization because of severe congenital defects by the time it became the charge of public education. Also, antibody loss[14,15] and the tendency of certain congenital rubella sequellae to undergo improvement with age (speculation from work in progress by Hardy) could result in further difficulties in detecting the mildly affected preschool child.

## Summary and Conclusions

Early reports of the 1964 rubella epidemic led to predictions that excessive numbers of defective children might prove burdensome to the health and educational facilities of the state in the early 1970s. A pilot epidemiological survey by the Maryland State Departments of Health and Education sought evidence concerning this question in the summer of 1968. A sample of 590 preschool children residing in Frederick County were studied with multiphasic screening followed by diagnostic evaluation. Of those at risk, 1.8% were found to have defects compatible with congenital rubella sequellae, but only 0.3% could be proven to have congenital rubella syndrome.

Furthermore, no significant increase in isolated defects typical of congenital rubella was found between a comparison and a study group. While the routine multiphasic screening of preschoolers could be seen to have considerable merit, it was concluded that further screening efforts in the general population at this time would not yield sufficient numbers of rubella-damaged children to justify the expense. The discrepancy between early predictions and survey findings was probably due to differences in estimation techniques and possibly to the tendency of some rubella victims to undergo improvement of mild sequellae with age.

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*Acute CNS Manifestations.* Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

*Usage in Children.* Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Ambulatory Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

*Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

*CNS Effect.* Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

*Children Under 12 Years of Age.* Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Duration of Therapy.* Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

*Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

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*John Galsworthy*

FREDERICK J. BALSAM, MD, EDITOR

**rehabilitation medicine**

# EVALUATION AND MANAGEMENT OF LUMBAR DISC DISEASE

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## Introduction

Low back pain with varying degrees of severity is almost a universal problem. Various terminology such as lumbago, low back sprain, muscle spasm, and sacroiliac are descriptive terms frequently used; nevertheless, the predominant cause of recurrent attacks of low back pain is due to disruption of the intervertebral disc. There have been isolated references in medical literature for many decades associating low back pain with sciatica; however, the discogenic etiology was not[5] understood until 1934 when Mixter and Barr clearly showed that herniation of the lumbar intervertebral disc is the most common cause of sciatica.

Following this correlation the definitive surgical treatment was then described. Knowledge of the anatomy and pathogenesis of disc disruption are necessary for a clear-cut understanding of the problem. Since the practitioner is so often confronted with the problem of back pain, he must decide which cases should be treated conservatively and for how long and, of equal importance, when the patient should be referred for definitive therapy.

## Anatomy

Disruption of a lumbar intervertebral disc occurs in the 4th and 5th lumbar intervertebral spaces in roughly 90% of the cases. This knowledge is helpful in localizing the level of the lesion since the central disposition of the 5th lumbar nerve root is the medial dorsal portion of the foot and great toe, while the first sacral root supplies the lateral portion of the foot and outer toes. Subjective numbness affecting these areas enables one to localize the level of the herniation. However, many cases of disc herniation occur in the absence of sensory deficit and motor weakness. Compression of the 5th lumbar nerve root may produce weakness of dorsiflexion of the foot and great toe, and plantar flexion weakness is sometimes noted with compression of the 1st sacral root.

The intervertebral disc consists of two structures. The nucleus pulposus is a small round structure of semi-liquid gelatinous consistency, and this is surrounded by a crescentic wrapping of tough fibrous bands which is termed the annulus fibrosus. The intervertebral disc functions as a cushion or shock absorber between the intervertebral bodies and allows mobility of the lumbar spine. The annulus fibrosus receives its nerve supply from a small branch originating from the dorsal root and is sensitive to stretch.[1] The nucleus has no nerve supply and is, therefore, insensitive.[2]

## Pathogenesis

The disruptive process begins with tearing and fragmentation of the annulus fibrosus, which for the most part is due to chronic stress such as lifting, bending, and movements of the lumbar spine. This early stage of degeneration of the annular fibers may be mildly symptomatic or may evoke a severe attack of low back pain. With fragmentation of the annular fibers, edema very likely occurs in the structure with coincident stimulation of the nerve endings. The attack comes to an end when the edema subsides, and the patient may have no further trouble until another such incident occurs. Generally,

after repetitive attacks of low back pain, the annulus weakens sufficiently so that bulging or protrusion of the cartilage occurs. The majority of herniations occur in the lateral position and, for this reason, the pain is usually localized to one side or the other.

Central herniation may cause a more diffuse soreness. Protrusion of the disc most frequently causes referred pain to the gluteal region and, as further compression of the root occurs, the pain follows the distribution of the sciatic nerve, ie, the posterior thigh and posterior lateral portion of the calf of the leg. Occasionally, the pain is referred to the inguinal region which is the anatomical distribution of a small branch of the 1st sacral root which gives referred pain to this area.

The final stage in the process is that of rupture of the nucleus through the annulus fibrosus, which allows a free fragment of cartilage to extrude into the extradural space through a tear in the posterior longitudinal ligament, or it may extrude beneath the ligament. When this rupture occurs, the pain pattern frequently changes in that the low back pain may disappear and, due to the compression of the nerve root, pain is then transferred to the distribution of the sciatic nerve. The continued presence of both back and leg pain usually indicates a moderate degree of protrusion without frank rupture of the annulus.

### Differential Diagnosis

Recurrent attacks of low back pain associated with sciatic are due to lumbar disc disruption until proven otherwise. Needless to say, it is necessary to exclude other causes of back pain which may or may not be associated with radicular pain. Some of the more common ancillary causes are kidney pathology, metastatic disease, infections of the lumbar spine such as tuberculosis and septic disease, and retroperitoneal involvement from neoplastic disease; occasionally, an aortic aneurysm may be present. Specific points in the history may be helpful. History of injury to the back may at first suggest discogenic disease. However, it should be emphasized that frequently no specific traumatic episode can be elicited.

Secondly, inquiries into what aggravates the pain and what relieves it should be made. Frequently, lying down will improve discogenic pain, whereas pain associated with tumors (either primary or secondary) of the spinal column will not be relieved by lying down. Coughing, sneezing, and other Valsalva maneuvers will frequently aggravate pain (this is true of any other intraspinal lesion). The pain pattern should be assessed. Radicular pain radiating to the leg will





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not only strongly suggest a ruptured disc, but may also indicate the exact location of the herniation as discussed above.

If radicular pain is present, it may be confused with either ischemic claudication secondary to occlusive vascular disease or hip disease. The former is ruled out by lack of a specific dermatomal pain pattern and the examination of the pulses. Hip disease is ruled out by a single maneuver: with the patient in the supine position, both the knee and the hip are flexed; the hip is rotated, using the distal leg as a lever (Patrick's maneuver). This test is generally painless in the patient with discogenic disease, but is exquisitely painful in the patient with either acute or chronic hip joint disease. Neurologic deficit should be looked for specifically, sensory loss and weakness. Rarely, patients with acute massive midline intervertebral disc herniations may develop urinary or fecal incontinence; the patient should be promptly referred for definitive treatment since this is a surgical emergency.

## Clinical Evaluation and Management

**Stage of Protrusion.** Patients in this stage of the disease will usually respond to conservative management, particularly if it is the first episode. Physical findings in these patients will generally be limited to the back, ie, paravertebral muscle spasm, scoliosis, and restricted movements of the lower trunk. There will be a positive straight leg raising test (Lasegue's sign). This maneuver will produce back pain, but not leg pain, indicating that nerve root impingement is not present.

The best treatment for the patient who presents with an acute backache due to musculoskeletal problems is complete rest on a firm mattress, heat to the painful area, and enough analgesia—narcotics if necessary. In the case of discogenic backache, this kind of treatment is especially necessary and may have to be continued as long as two weeks or more. Skeletal muscle relaxants and pelvic traction may also be used, but the benefit from the traction apparatus may be largely psychological. At least, the patient has a difficult time getting out of bed with such a harness holding him down.

There is no place for exercise during this acute painful state. Diathermy feels fine while it is on but is probably no better than a heating pad except for its psychologic benefit. With this kind of program many patients will have a remission or considerable improvement in back and radicular leg pain. Such long-term programs (including various ointments, liniments with massage, and, often, heat lamps) are of no value in the treatment of this condition.

Since the natural history of symptomatic lumbar disc disease is frequently one of improvement, the initial management should almost always be conservative. However, after a week or so, if the pain has not shown significant improvement, the other causes of back pain should be more thoroughly investigated; plain X-rays of the back should be obtained to rule out bony abnormalities of the lumbosacral spine. It should be emphasized that if the pain is discogenic the vast majority of patients will improve at this stage. If pain persists despite these measures, the patient should be referred for evaluation for other primary etiologies.

As part of the conservative treatment of lumbar disc disease, exercise is commonly prescribed. Many physicians, including neurosurgeons, frankly state that exercise in disc disease is of no benefit. Armstrong,[3] an English author, writes in his textbook on disc diseases that nothing could be worse for disc disease than flexion exercises; if exercise is indicated, it should be hyperextension exercises to strengthen the paraspinous muscles to give support to the mechanically deranged spine. Exercise is never to be used when there is acute or severe pain. He absolutely condemns manipulation as a procedure which cannot be controlled, and offers the opinion that, for every patient temporarily relieved of discogenic pain, many others are given foot-drop or otherwise hurt. Most everyone agrees with this, although the patient who is occasionally "cured" in the chiropractor's office appears as an *ignis fatuus* among the many sufferers of a condition which is difficult to treat.

Disc disease can have a component of backache due to structural changes in the vertebral articulations resulting in osteoarthritis, stretching or pinching of spinous ligaments, synovitis, and muscle spasm. Particularly when this mechanical derangement is complicated by postural changes, a rational exercise program may relieve backache symptoms considerably. A good part of the relief results from the beneficial effect of gently stretching muscles in spasm. This kind of muscle spasm is often seen after back surgery and will respond to heat and active stretching exercises, such as gently rocking the body forward, as in attempting to touch the toes from a seated position. The patient who has disc disease with intermittent backache often responds to this kind of treatment although the radicular leg pain is not helped.

The postural aspect of backache is a well-known entity. It generally results from forward

pelvic tilt, with increased lumbar lordosis, weak abdominal muscles, or tight hamstrings, and tight hip flexors, along with contracted paraspinous musculature. Williams designed an exercise routine and a brace for the treatment of postural backache. The exercise program most often used in the United States is the Williams flexion exercise routine.

The program generally consists of strengthening abdominals, stretching tight back and leg muscles, attempting to decrease lumbar lordosis by pelvic tilting, and conscious attention to good postural alignment. Most physical therapists have simple drawings of each exercise, and the patient can be quickly placed on a home program.

All patients with postural backache should be tried on this program and continually urged to form the habit of "good posture." Certainly the patient with disc disease who is committed to conservative treatment should be analyzed for these postural defects.

Lumbar supports and braces have their place in conservative treatment, and each physician who prescribes them has his favorite type. They essentially prevent flexion—extension movements of the spine and work best where there is low back instability. Any of the commercially available lumbosacral corsets with steel back stays and good abdominal support, or a low back brace which fits comfortably (such as the Knight Spinal Brace) should do the job. Back braces should never be put on a patient as a permanent remedy since they compound the problem in time by fostering weak and contracted back muscles.

**Stage of Herniation.** Unlike those patients in which the pain is limited to the back, these will probably not respond very well to conservative management and should be referred for evaluation for definitive surgical therapy. Examination of these patients may again show localized back findings; in addition, the Lasegue maneuver will reproduce the radicular pain to the leg. Furthermore, the straight leg raising test on the side opposite the radicular pain may reproduce it. This is almost pathognomonic of a herniated intervertebral disc or other intraspinal pathology. These patients frequently show signs of neurologic injury. Injury to the 5th lumbar root may produce weakness of dorsiflexion of the foot or hypalgesia over the great toe. Injury to the 1st sacral nerve root may be manifested by weakness of plantar flexion of the foot and toes, weakness of inversion of the foot, decrease or absence of the ankle jerk, and hypalgesia of the lateral foot or small toe.

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## Myelography and Surgical Therapy

Myelography is the definitive diagnostic procedure for evaluation of intraspinal pathology. Myelography is frequently helpful, but by no means essential, to the diagnosis of lumbar discogenic disease. History and physical examination may not only make the definitive diagnosis, but may also localize the level of the herniation. Therefore, myelography may not be necessary. Myelography and electromyography are generally indicated in those cases in which intraspinal disease other than lumbar disc disease is specifically suspected, or in which the diagnosis is somewhat uncertain. The latter situation frequently exists in those cases involving workmen's compensation or litigation.

The standard surgical procedure involves a subtotal discectomy; ie, the offending disc is exposed, and enough intervertebral disc material is removed to effect decompression of the surrounding tissues. It is neither necessary nor possible to remove the entire intervertebral disc. The procedure requires very little bone removal, and the articulating facets are left intact; therefore, fusion of the spine is not usually necessary. At one time, spinal fusions were frequently done following intervertebral discectomies; however, it has been shown that results with or without spinal fusion are not significantly different.[4]

Since spinal fusions carry a higher morbidity and longer convalescence, they are generally done only for specific reasons; ie, instability of the spine such as seen following trauma, in spondylolisthesis, and in other disorders of the bony and supporting structures of the spine. Although instability of the spine may be associated with rupture of the intervertebral disc, the vast majority of ruptured intervertebral discs are not associated with an unstable spine. Good functional results from this operation can be expected in at least 80% of the cases in which there are good clinical and laboratory indications of a herniated disc with nerve root impingement.

**Acknowledgment**

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## What Bears and Pigs Have In Common: Trichinosis

Don't eat raw bear meat!

It may contain trichinosis, warns an article in a recent issue of the *Journal of the American Medical Association.*

Trichinosis organisms, found largely in uncooked pork, infiltrate the body tissues, leading to muscle pain, stiffness, weakness, painful breathing, swelling around the eyes, rash, weight loss, and high fever for several weeks. Complications include general prostration, pneumonia, and sudden heart failure.

An editorial in the same issue relates that eating raw polar bear meat may have caused the death of three Swedish balloonists in 1897.

A modern day example is described in the article, in which 17 out of 18 people who ate uncooked bear meat contracted trichinosis. In October 1970, a hunting party shot an apparently healthy black bear in Idaho. The meat was immediately cut into thin, narrow strips for "jerky," made by soaking the strips in brine for three days and then smoking them for two days.

Twelve of the 18 who ate the uncooked meat came down with symptoms of trichinosis; five showed positive test signs of disease; and one escaped. This is the second reported outbreak of human trichinosis due to bear meat in the United States.

The article warned that while the number of bears shot and eaten in this country is not known, it is estimated that the prevalence of this infection among bears in the United States is "four times greater than the prevalence in garbage-fed swine." This may be because bears leave their "sylvan retreats and join man in picnic areas and suburbia, banqueting on his raw garbage."

Two more outbreaks of human trichinosis have been reported since the article was prepared. Both occurred in California in August 1971 — one from eating bear meat jerky, the other from eating rare bear meat steaks.

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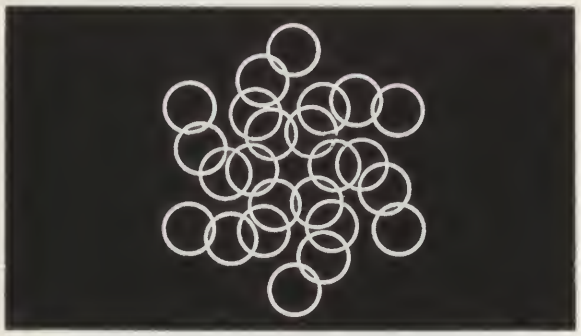
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

# PROJECT REHAB: A PROGRESS REPORT

**MISS SHIRLEY E. COOKE**
**Alcoholism Program Coordinator**
**Provident Comprehensive Neighborhood Health Center**
**(PROJECT REHAB)**
**Baltimore**

## I. Background

In accordance with the Dec 31, 1969 amendment to the Economic Opportunity Act of 1964, which established and provided funds for "Alcoholic Counseling and Recovery Programs," the Provident Comprehensive Neighborhood Health Center made application for and developed such a program.

Although the program was funded in July 1970, administrative problems, inability to recruit qualified staff, and lack of space delayed program implementation. A program coordinator was not secured until December 1970 and the program did not become fully operational until March 1971.

## II. Facility Acquisition

As noted in the project application, lack of space for program operations made it necessary to locate in a satellite center in close proximity to the parent center. Housing in the area in which we are located is at a premium; it is either structurally deteriorated, unavailable, or available at exorbitant prices. In addition to the basic housing problems of a depressed area, we had to contend with the stigma attached to the problem of alcoholism in locating the Alcoholism Center.

Despite vigorous community organization and coordination activities prior to program implementation, the first attempt at establishing the center was aborted because of neighborhood opposition. However, with the aid of some of the most vocal opposition leaders (to the original proposed site) and a neighborhood church group, the center was located at its present site in a building owned by the New Shiloh Baptist Church at 821 W Lanvale St.

## III. Staffing Pattern

The staff consists of a program coordinator, senior counselor, three staff counselors, and a secretary-counselor—four females, two males. One staff member is a recovering alcoholic.

Four staff members, including the program coordinator, are graduates of the six-month training program for alcoholism counselors offered by the Baltimore City Health Department Alcoholism Center.

## IV. Service Description

The program is designed to serve those persons in the Provident Comprehensive Neighborhood Health Center's catchment area—census tracts 16-01, 17-01, 17-02, 17-03, and minute portions of 18-01 and 18-02—below the poverty level who are afflicted by alcoholism.

It is designed to provide a vigorous outreach and ambulatory care program for the poverty level alcoholic and his family in conjunction with the fully comprehensive family-oriented services of the Provident Comprehensive Neighborhood Health Center (PCNHC). PCNHC seeks to attack the roots of deprivation through preventive and curative medical and dental care, social and educational services, training of neighborhood residents for paramedical occupations, and related services.

A. **Objectives.** The objectives of the program

are to identify the alcoholic, bring him early to a therapeutic situation, help him accept and understand his condition, and to guide him to sobriety. Additionally, it aims to provide community education oriented towards gaining broad acceptance of the alcoholic as a person in need of help, encouraging the mobilization of community resources to help the alcoholic and his family, and preventing the development of alcoholism among adolescents and young adults.

B. **Availability of Services.** The program is based in a community outreach center designed specifically for the service at 821 W Lanvale St. The center operates 60 hours per week, Monday through Friday, 8:30 AM to 9:00 PM.

C. **Referrals.** Appropriate referral mechanisms have been established with agencies and other health providers. Referrals are accepted from any agency or institution, organization, family members, friends, or self referrals. Table 1 shows the distribution of sources of patient referrals for 1971.

**Table 1: Comparison of Source of Referrals With Number of Patient Changes — 1971**

| REFERRAL SOURCE | TOTAL REFERRALS | TOTAL CONTACTS |
|---|---|---|
| PROVIDENT HOSPITAL COMPLEX — | | |
| Provident Hospital | 66 | 26 |
| PCNHC | 76 | 68 |
| Provident Community Mental Health | 3 | 3 |
| Provident House | 6 | 3 |
| STATE HOSPITALS | | |
| Mount Wilson | 10 | 4 |
| Springfield | 7 | 5 |
| Crownsville | 1 | 1 |
| Other Alcoholism Facilities | 3 | 3 |
| Baltimore City Hosp. | 4 | 1 |
| Police Dept & Courts | 7 | 7 |
| Dept. of Social Services | 2 | 2 |
| Community Action Agency | 6 | 5 |
| Self Referrals | 28 | 28 |
| Family Member | 4 | 3 |
| Friends | 7 | 7 |
| Outreach | 6 | 6 |
| Unknown | 19 | 19 |
| Threshold House | 1 | 1 |
| TOTALS | 256 | 192(75%) |

Out of 256 recorded referrals from various sources, 75% resulted in patient contact. Many outreach or community follow-up contacts could not be effected due to inaccurate addresses, patients moving, or patients residing outside of the area served.

It can be noted that 59% of all patient referrals emanate from the Provident Hospital complex, with the greater number coming from Provident Comprehensive Neighborhood Health Center. Further, an interesting observation is the percentage of referrals from family, friend, and self (11%) which might be an indication of increasing community acceptance of PROJECT REHAB.

D. **Program Services:**

1) Individual and group counseling, where the patient can work through problems of personal and environmental adjustment with freedom and confidentiality.

2) Family counseling, where all the members of the family are encouraged to take part in the recovery of the patient.

3) Job counseling, to help that individual who has been chronically unemployed due to his illness.

4) Regular AA meetings to involve the patient with the self-help concept of treatment.

5) Recreation therapy, to encourage the patient to develop new interests and provide a place where they can relax without the use of alcohol.

6) Outreach community follow-up to maintain contact with and provide support for difficult cases.

7) Acute intervention and emergency services, including transportation for medical emergencies and state hospitalizations.

8) Coordination and referral of alcoholic patients for care of total health and social needs within and outside of the Provident Comprehensive Neighborhood Health Center, including medical, psychiatric, dental, and social service aspects.

9) Structured community education programs designed to modify attitudes towards alcoholism and alcoholics.

10) Structured inservice alcohol education for staff and community workers, providing an overview of alcohol and alcoholism and exploring techniques of early detection and casefinding.

E. **Statistical Summary of Program Services Provided.** Since the beginning of program operation, March 1, 1971 through Dec 31, 1971, PROJECT REHAB has served 192 different primary patients (this figure does not include family members). Total patient encounters in group and individual counseling sessions have been 2,657 and the total number of participants in educational and information sessions have been 941. Table 2 shows a more detailed breakdown of the above data.

**Table 2: Program Services Breakdown, March-Dec 1971**

**INDIVIDUALS SERVED**

I. Total Different Patients Seen **192**
   A. Patients Seen in Emergency or One Contact **20**
   B. Patients Seen in Limited Services or Cases Lasting less than two months **56**
      (Male — 40 or 71%, Female — 16 or 29%)
   C. Patients Seen in Ongoing Case Status **116**
      (Male — 84 or 72%, Female — 32 or 28%)

II. Total Number of Individual Counseling Sessions **1349**

III. Total Number of Group Meetings Held **134**

IV. Total Individuals Seen in Groups **1308**

**ALCOHOL EDUCATION ACTIVITIES**

I. Total Staff and Agency Information Sessions **17**

II. Total Participants in Staff and Agency Information Sessions **358**

III. Total General Community Alcohol Information Sessions **25**

IV. Total Participants in General Community Alcohol Information Sessions **583**

## V. Evaluation of Patient Services

In order to present a more meaningful picture of the effects of treatment on patients, it is deemed necessary to present a profile of patients served. Table 3 represents selected characteristics of 172 patients in ongoing treatment status and limited services, as defined earlier, at first contact. It will not include those patients (N = 20) seen as emergencies or one contact.

A realistic evaluation of any alcoholism rehabilitation program must deal with the question of whether or not total abstinence is the only valid criterion of "success." We choose not to consider this to be the case. While total abstinence is certainly the ultimate goal, our singular program evaluation is based on significant, positive changes in the patient's life due to treatment of alcoholism. The population is evaluated at six-month and one-year intervals using the following criteria as measurements of significant changes: length of sobriety, changes in attitudes toward drinking, alteration of drinking patterns, changes in employment status, changes in family relationships, changes in edu-

**Table 3: Selected Patient Characteristics of 172 Patients in Limited Service and Ongoing Case Status — 1971**

| VARIABLE | | LIMITED SERVICE N= 56 NO. | % | ONGOING CASES N= 116 NO. | % | TOTAL PATIENTS N= 172 NO. | % |
|---|---|---|---|---|---|---|---|
| **SEX** | MALE | 40 | 71 | 84 | 72 | 124 | 72 |
| | FEMALE | 16 | 29 | 32 | 28 | 48 | 28 |
| **AGE** | 20-24 | 3 | 6 | 5 | 4 | 8 | 4 |
| | 25-34 | 18 | 32 | 22 | 19 | 40 | 23 |
| | 35-44 | 10 | 17 | 44 | 38 | 54 | 32 |
| | 45-54 | 8 | 14 | 33 | 28 | 41 | 24 |
| | 55-64 | 7 | 13 | 12 | 11 | 19 | 11 |
| | 65 and over | 1 | 2 | 0 | 0 | 1 | less than 1 |
| | Unknown | 9 | 16 | 0 | 0 | 9 | 5 |
| | *(MEDIAN AGE) | (MALE-34, FEMALE-34) | | (MALE-43, FEMALE-37.5) | | (TOTAL MEDIAN-40) | |
| **MARITAL STATUS** | | | | | | | |
| | Never Married | | | | | 42 | 24 |
| | Married | | | | | 37 | 21 |
| | Separated | Not Available | | Not Available | | 58 | 34 |
| | Divorced | | | | | 6 | 3 |
| | Widowed | | | | | 12 | 8 |
| | Unknown | | | | | 17 | 10 |
| **EDUCATION** | | | | | | | |
| | Grade Completed 0-6 | 5 | 9 | 25 | 22 | 30 | 17 |
| | 7-8 | 8 | 14 | 12 | 11 | 20 | 11 |
| | 9-11 | 9 | 16 | 35 | 30 | 44 | 26 |
| | High School Graduate | 7 | 13 | 20 | 17 | 27 | 16 |
| | Some College | 1 | 2 | 6 | 5 | 7 | 4 |
| | College Graduate | 0 | 0 | 0 | 0 | 0 | 0 |
| | Unknown | 26 | 47 | 18 | 15 | 44 | 26 |
| | *(MEDIAN GRADE LEVEL) | (MALE-7th, FEMALE-9th) | | (MALE-9th, FEMALE-9th) | | (MEDIAN OF TOTAL-8th) | |
| **SOURCE OF INCOME** | | | | | | | |
| | Public Assistance | 17 | | 75 | 64 | 92 | 53 |
| | Disability, Retirement | 3 | | 13 | 11 | 16 | 9 |
| | Employed | 9 | | 20 | 17 | 29 | 18 |
| | Housewife | 2 | | 2 | 2 | 4 | 2 |
| | Unemployed | 7 | | 3 | 3 | 10 | 11 |
| | Unknown | 17 | | 3 | 3 | 20 | 11 |
| | Other | 1 | | 0 | 0 | 1 | less than 1 |

*Unknown not Included

cational status, length of time in continuous treatment, and changes in attitudes toward self and society. The absence of adequate measurement mechanisms for the intangible variables makes it impossible to deal with them in a meaningful way at this time; however, data will be presented for the more tangible ones.

The following analysis of significant, positive changes in the lives of patients due to treatment of alcoholism is based on persons who have been in treatment case status for over two months (N = 116).

A. **Patient's Use of Alcohol.** Questions to be considered in this area are: What, if any, changes in attitudes toward drinking have been noted? Has the patient experienced any real period of sobriety? Have there been any noticeable changes in drinking patterns? Reduction of drinking episodes? Decrease in drinking bouts? Table 4 shows changes, if any, of patient's use of alcohol.

**Table 4: Patients use of Alcohol**
N= 116

| | NO. | % |
|---|---|---|
| NO CHANGE | 41 | 35 |
| CHANGE IN PATTERN | 6 | 5 |
| SOBER-LESS THAN 1 MONTH | 1 | 1 |
| SOBER-1 to 3 MONTHS | 27 | 23 |
| SOBER-4 to 6 MONTHS | 12 | 10 |
| SOBER-7 to 9 MONTHS | 10 | 9 |
| SOBER-10 to 12 MONTHS | 2 | 2 |
| UNKNOWN | 17 | 15 |

B. **Changes in Employable Status or Economic Dependency.** In this area we address ourselves to changes in employability status. Questions to be answered are: Has the patient acquired a job, a better job, become involved in job training or vocational rehabilitation? What changes, if any, in welfare status have been noted?

Case analysis reveals that of 116 persons in ongoing case status, of whom 67% were either on public assistance or unemployed, six individuals secured jobs and seven are involved in job training programs since entering treatment. Additionally, three patients whose jobs were in jeopardy when initially entering the treatment program are now secure in their employment, four employed patients lost jobs, and two got better jobs. Table 5 shows a breakdown of changes in employable status or economic dependency.

C. **Changes in Marital Status and Family Relationships.** Provision of family counseling and support in the treatment of alcoholism constitutes one of the vital aspects of the program. It is estimated that each alcoholic affects three to four family members in one way or another. It should be noted that while family services are provided, family members are not counted as primary cases. Thus, case figures (N = 116) may be somewhat misleading. Oftentimes counseling of family members is equal to or greater than the time devoted to counseling the primary case member. In this respect supportive family counseling has contributed to the "firming up" of some family relationships, intervened in some impending separations, and effected reconciliations.

To present an overview of family structure in the PROJECT REHAB temporary catchment area, we show data in Table 6 comparing family structure in census tracts 16-01, 17-01, 17-02, and 17-03 with family structure of 116 ongoing cases in treatment for alcoholism. The minute portions of 18-01 and 18-02 served (7.96% and 10.57%, respectively) have been omitted.

It can be observed that the ongoing caseload of PROJECT REHAB reflects a higher proportion of husband-wife families and families with children than does the general catchment area. The low female-headed family figure in proportion to the general catchment area is apparently in keeping with the national trend of "the hidden woman alcoholic."

**Table 5: Changes in Employable Status of Patients in Treatment Program — 1971**

| SOURCE OF INCOME AT CONTACT | PATIENT CONTACTS | | NOTED CHANGES | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | JOB TRAINING | | EMPLOYMENT | | BETTER JOB | | LOST JOB | |
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| Public Assistance | 75 | 64 | 5 | 7 | 5 | 7 | — | — | — | — |
| Disability or Retirement | 13 | 11 | 1 | 10 | 1 | 10 | — | — | — | — |
| Employed | 20 | 17 | — | — | — | — | 2 | 10 | 4 | 20 |
| Unemployed | 3 | 3 | 1 | 33 | — | — | — | — | — | — |
| Housewife | 2 | 2 | — | — | — | — | — | — | — | — |
| Unknown | 3 | 3 | — | — | — | — | — | — | — | — |
| **TOTALS** N= 116 | 116 | 100 | 7 | 6 | 6 | 5 | 2 | 2 | 4 | |

Table 6: Comparison of Family Structure of Project Rehab — PCNHC Temporary Catchment Area with Family Caseload Structure — 1971

| TYPE OF FAMILY | *CENSUS TRACTS: 16-01, 17-01, 17-02, 17-03 | | PROJECT REHAB ONGOING CASES | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Husband-Wife Family | 1606 | 48.3 | 33 | 56.9 |
| Female-Headed Family | 1491 | 44.9 | 15 | 25.9 |
| + Other Male Head | 225 | 6.8 | 10 | 17.2 |
| Families with Children under 18 | 1743 | 52.5 | 39 | 67.2 |
| TOTAL — ALL FAMILIES | 3322 | | •58 | |

* Source: 1970 Census Data (First Count Tapes)
\+ Includes Common-law "Marriages"
• Represents number of families in Caseload of 116

Of the families provided with counseling services, 12 (20.7%) show evidences of a better understanding of the problem of alcoholism and apparently have better relationships. Of this number two separated families were reconciled and one female head of family was reconciled with her children. Additionally, one family was separated.

D. **Changes in Educational Status.** One positive measurement of decreased dependency on alcohol and increased self-confidence and desire to achieve is the attempt to increase educational skills. The question to which we addressed ourselves was: Are there any indications of increased skills in terms of academic advancement (high school equivalency, etc)?

Case analysis reveals that three patients have begun work on high school equivalencies and one person has begun part-time work on the college level.

E. **Changes in Residence.** One of the observed phenomenon of the catchment area is the tendency towards communal living situations among some alcoholic patients. At least four such group homes have been located during the past year. One had been closed at the end of the year, with its members moving to more favorable quarters.

We attempted to note any changes in residence—successes in establishing better living conditions or moving to a better or poorer environment. Case analysis revealed 12 patients (10%) had been successful in obtaining more suitable living quarters.

## VI. Evaluation of Alcohol Education Activities

The effect of alcohol education and information activities on the population is difficult to measure; however, we shall use, as a primary indicator of effectiveness, the attendance rate and the number of new source referrals generated as a result of exposure to alcohol and alcoholism education Information has been disseminated through the media, field and center activities aimed at the broad community, and inservice education aimed at health providers and other staff of the Provident Comprehensive Neighborhood Health Center and community workers of neighborhood-based agencies and organizations such as CAA Centers and Model Cities Neighborhood Councils.

A major inservice education effort was mounted during September and October 1971. It consisted of one week of seminars on alcoholism followed by four consecutive weekly sessions tailored for outreach workers. In order to insure maximum participation, it was planned with PCNHC team coordinators, nursing and social service supervisors, outreach services coordinator, and a community health aide representative.

Attendance per session was generally good, averaging about 25. The Health Center was well represented by most service areas; however, physicians and supervisory personnel were noticeably absent. Dolphin St and Pennsylvania Ave CAA Centers participated minimally, and not at all in the planning process, to which they were invited. This is reflected in the low number of referrals (1) from these two areas. Ironically, these are the only CAA Centers located in the temporary target area of the Provident Comprehensive Neighborhood Health Center. On the other hand, the Calhoun St Center had maximum participation which is reflected in the four referrals made since the alcoholism information sessions. See Table 1.

General community alcohol and alcoholism education activities are aimed at increasing the awareness of the community of the magnitude of the problem with the hope that this insight will help to alleviate the prejudice and misunderstanding surrounding alcoholism.

Noticeably, 44, or 22.7% of all patient contacts, were referred by self, family, friend, or resulted from outreach contact.

## VII. Problem Areas

A. **Insufficient Staff.** It has been observed that our patients respond more readily to individual counseling and, because of their multiple social and psychological problems, require more intensive work. While this is more costly in terms of staff time, if rehabilitation is the goal, flexibility and imagination are the keys. Patient referrals are steadily increasing and the need for

more alcoholism education is in evidence.

B. **Limited Service Areas.** PROJECT REHAB represents the only outpatient and outreach facility for alcoholics and their families in the Provident Hospital catchment area. Attempts to limit referrals to the PCNHC temporary target area have been less than successful. Ideally, the outpatient alcoholism program should complement the services of Provident House and the West Baltimore CAA Centers, but catchment area limitations prevent this. The need for program expansion is pressing.

C. **Job Development Problems.** The majority of our patients have developed few, if any, job skills and are poorly educated. Unemployment is higher for this area and this group than the general population, and manpower programs are not able to produce in the manner that it would be hoped.

### VIII. Future Program Priorities and Recommendations:

A. To make a major thrust in the area of alcohol and alcoholism education aimed at early detection and prevention of alcoholism.

B. To work on program expansion through increased manpower.

C. To develop more effective working relationships with neighborhood-based agencies and resources.


## CONSIDERING INCORPORATING?

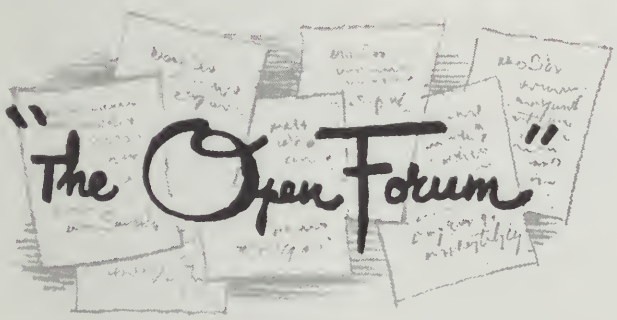
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## INSECT BITES AND STINGS

There is a need for more information on the biting insects because severe reactions do occur from biting as well as stinging insects. There is also a need for case reports of reactions and results of hyposensitization.

I would like physicians to send me case reports of patients who have had allergic reactions to biting insects and the results of skin testing and hyposensitization, if these were done. I would appreciate detailed case reports if possible but a summary would be all right.

I am compiling case reports of allergic reactions to biting insects, ie, mosquitos, fleas, kissing bugs, bed bugs, gnats, and flies — including horsefly, sandfly, deerfly. I am also interested in reactions to fire ants.

Include in your reports the history of the type of reaction and complications, if any; the immediate treatment; and the results of desensitization attempts.


CLAUDE A. FRAZIER, MD
4-C Doctors Park
Asheville, NC 28801

# What's on your patient's face...

may be more important than his chief complaint

# The lesions on his face may be solar/actinic—so-called "senile" keratoses...and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



*Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.*

## Sequence of therapy/ selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; the reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

## Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.



*Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5%-FU cream. Reaction has subsided. Residual scarring not seen except for that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.*

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Multiple actinic or solar keratoses.

**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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## This patient's lesions were resolved with

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*Indications:* Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
*Contraindications:* Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoglycemia.
*Warnings:* Use during pregnancy is to be avoided.
*Precautions:* 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended

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n the presence of azotemia or in any clinical ituation that predisposes to sustained hypoten- ion that could lead to lactic acidosis. To ifferentiate lactic acidosis from ketoacidosis, eriodic determinations of ketones in the blood nd urine should be made in diabetics previously tabilized on phenformin, or phenformin and nsulin, who have become unstable. If electrolyte nbalance is suspected, periodic determinations hould also be made of electrolytes, pH, and the ctate-pyruvate ratio. The drug should be with- rawn and insulin, when required, and other orrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

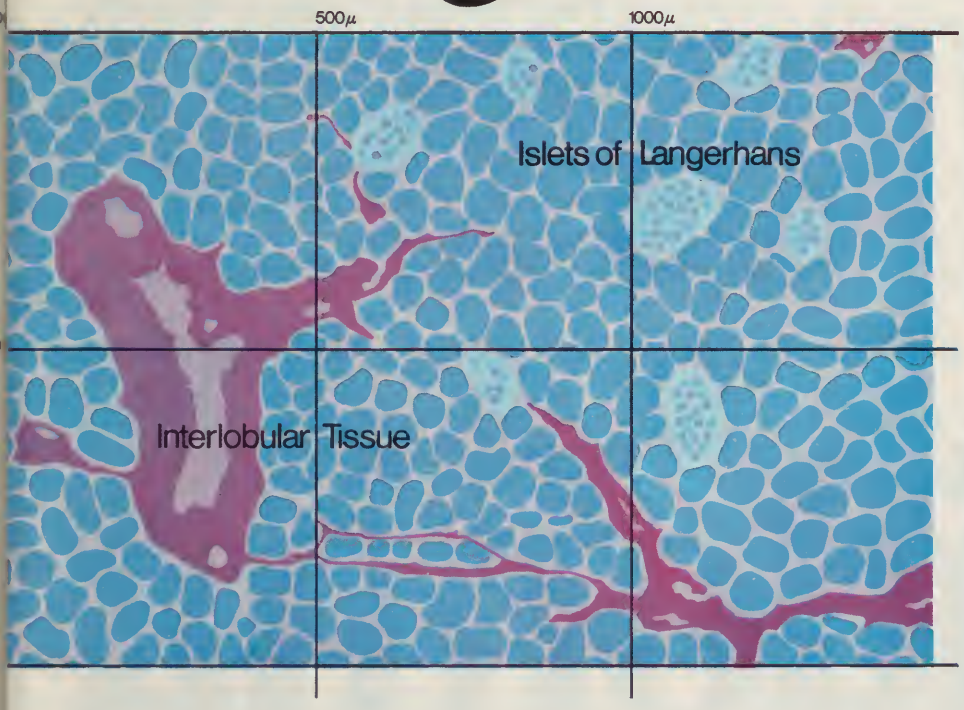
*Adverse Reactions:* Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B)98-146-103-C

*For complete details, including dosage, please see full prescribing information.*

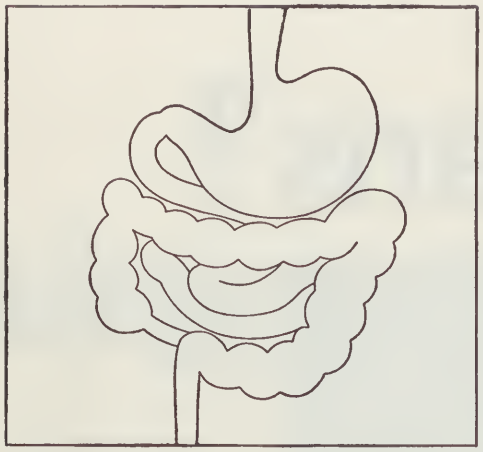
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# of Langerhans?




Before using DBI-TD or any oral hypoglycemic, please read the prescribing information concerning dosage, warnings, contraindications, precautions and adverse reactions.

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## Information searching: a library service

The Medical and Chirurgical Faculty Library currently receives two to three requests each day from its members for information about specific subjects. As a part of its services, the library searches the book and periodical literature at its disposal and composes subject bibliographies in answer to these requests. This activity consumes approximately five man-hours of library staff time each day. These bibliographies allow a physician to examine articles and books dealing with his subject and, if he desires, to obtain copies of portions of these through the library's Xeroxing policy.

### Some resources

The library uses numerous tools in providing its services. The National Library of Medicine's **Index Medicus** is probably the source most frequently relied upon. **Index Medicus** provides a subject and author index to approximately 2,300 of the world's biomedical journals. The cumulative volume of **Index Medicus** for 1970 contained over 9,000 pages. The library also receives the abstract journals published by **Excerpta Medica** of the Netherlands. **Excerpta Medica's** 38 monthly abstract journals cover all aspects of the biomedical sciences. Its English abstracts of articles from journals throughout the world are especially beneficial for foreign language articles, and articles in journals that are not easily available. In addition to these major indexes, the library also receives several other, more specific indexing and abstracting journals: **Artificial Kidney Bibliography, Endocrinology Index,** and **Toxicology Bibliography** among them.

The library is kept aware of new monographic publications through the National Library of Medicine's **Current Catalog Proof Sheets,** which arrive twice a week. These indicate the latest additions to the National Library of Medicine's collection. From these and from publisher's advertisements and catalogs, the library attempts to select those new books which will be of use and interest in the Faculty's library. The subjects of information requests by Faculty members are influential in selecting new books for purchase.

### Requesting an information search

The success of an information search is somewhat dependent upon the requestor. It is usually best for the physician himself to call the librarian. The request should be stated as specifically as possible. If the most recent information on a subject is desired, it is especially helpful to provide a reference to an earlier article that exemplifies the kind of information needed. The librarian needs to know exactly what the physician wants. (It has happened that we have spent hours researching an obscure subject, plus the time to prepare and type a bibliography, only to have the doctor return it saying that it is not at all what he wanted.) Also, the physician should indicate how much material he needs. Sometimes it is helpful to know why the information is needed. If one or two recent articles will suffice, it is expensive and wasteful to prepare a list of 75 articles from 1945 to date for the doctor.

### How we go about it

There is no one way to approach an information search. The method is very much determined by the nature of the question. In a typical request (eg, on "Seminoma and germinoma of the mediastinum") the terminology is first checked in a medical dictionary. With this background, the

librarian can search the library's subject catalog to see what books on the subject are available in the library. Textbooks and outlines can help the librarian to become more familiar with the subject. Often a recent book will contain a good bibliography, and sometimes this is all that is needed. If additional or more recent information is required, the librarian then begins to search the subject in **Index Medicus,** and whatever other tools are necessary. If there is some doubt as to whether the information being found is relevant, the librarian will attempt to get in touch again with the physician.

When the references have been gathered, they are usually typed in a bibliography. One copy is kept by the library for future reference, and another is sent to the requestor. If the request was for a couple of articles, or if the requestor indicated he wanted copies, some of the items on the bibliography will be Xeroxed and mailed at this time.

## MEDLARS, MEDLINE, etc.

The library sometimes gets requests for obscure subjects, or for subjects that would involve searching under several subject headings. Recent examples include "surgical means to correct snoring" and "how many years organs of an embalmed body remain useful for autopsy." These questions can be referred by the library to the computerized searching system called MEDLARS at the National Library of Medicine, and to MEDLINE (an on-line modification of MEDLARS) through the Welch Library at Johns Hopkins University. The time required for these computer searches varies. The result is a printout bibliography listing articles relevant to the subject from the last three years. Searches for earlier material can be run if a physician still needs more information.

The library's information searching service is available to all Med-Chi members. All it takes is a phone call or a letter. Try us!

## NEW ACCESSIONS – BOOKS (Arranged by Subjects)

### ANATOMY

QS 604 .L3 — **Medical embryology; human development, normal and abnormal.** Illus. by Jill Leland. 2d ed. Baltimore, Williams & Wilkins, 1969.

QS 517 .M2 — Langman, Jan

Matthews, James L. **Atlas of human histology and ultrastructure.** By J. L. Matthews and J. H. Martin. Philadelphia, Lea & Febiger, 1971.

### BIOCHEMISTRY

QU 120 .D2 — Dagley, S. **An introduction to metabolic pathways.** By S. Dagley and Donald E. Nicholson. New York, Wiley, 1970.

### BIOLOGY

QH 605 .S4 — Shah, Saleem A. **Report on the XYY chromosomal abnormality.** Chevy Chase, Md, National Institute of Mental Health, Center for Studies of Crime and Delinquency. (Public Health Service Publication, no. 2101)

### CARDIOVASCULAR SYSTEM

WG 205 .A9 — Ayres, Stephen M. **Care of the critically ill.** By Stephen M. Ayres and Stanley Gianelli, Jr. Illustrated by Meta E. Buehler. New York, Appleton-Century-Crofts, 1967.

### CLINICAL PATHOLOGY

QY 4 .B6 — Bologna, Camillo V. **Understanding laboratory medicine.** St. Louis, Mosby, 1971.

### DERMATOLOGY

WR 102 .E5 — **Biophysical properties of the skin.** Edited by Harry R. Elden. New York, Wiley-Interscience, 1971. (A Treatise of skin, v.1)

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# Board of Directors Meets

The Board of Directors met for five hours on March 14 to discuss the numerous items of business. Minutes of the Feb 8 meeting were approved as written.

Edward Kowalewski, MD, director, Division of Family Practice, University of Maryland, joined the meeting to discuss the recommendation made by the Medical Care Committee that the Society fund three family practice preceptorships this summer. The goal of the program is to interest students in entering family practice by giving them experience in treating patients in family medicine settings. The Board voted to approve the recommendation of the Medical Care Committee and to fund three preceptorships in the amount of $800 with the stipulation that the students who receive these funds be assigned to preceptors in the inner city and be requested to submit a report of their experiences in the fall to the Medical Care Committee.

Expansion plans of the North Charles General Hospital were discussed with the president of the medical staff, Allan H. Macht, MD. John Harvey, MD, disqualified himself from this discussion because of a conflict of interest resulting from his position at the Good Samaritan Hospital.

Plans for the North Charles would provide 50 additional beds—some surgical, some medical, and the majority for psychiatric care. Some apparent difficulty has arisen because there are presently 70 beds available at Good Samaritan, which is in the same geographic area, and which the State will not allow the hospital to open. These beds seem to be available for the same purposes as those proposed by North Charles General. The question arose as to the difference in staff privileges at the hospitals. It was felt that the Board could not oppose the expansion of North Charles, but that a committee should be appointed to review the problem of duplication of services in depth before a final decision is made.

D. Frank Kaltreider, MD, chief of the medical staff of Baltimore City Hospitals, joined the meeting and informed the Board of the proposal for the incorporation of the physician staff at City Hospitals. Salaries and fringe benefits offered by them are not competitive with those offered elsewhere and it is becoming increasingly difficult to attract high-quality medical personnel. The physicians, therefore, agreed to investigate the possibility of incorporating so that they could send bills and receive payment from Medicare and Medicaid and other insurance programs. A motion was made, seconded, and approved:

> "That the Baltimore City Medical Society Board of Directors is concerned with the necessity of attracting high-quality medical personnel to Baltimore City Hospitals and is aware that in order to do this competitive compensation must be offered. Therefore, the Board approves in principle the idea of the incorporation of the physicians at Baltimore City Hospitals."

The Professional Relations Committee had received several letters from insurance companies questioning whether a fee submitted by individual members of the Society was within the range of usual and customary. The question has arisen within the committee as to whether or how these letters should be answered. William Speed, MD, who has worked with this problem for some time on the State level, joined the meeting for the discussion. It was agreed that if the Society did not respond to these letters government and the insurance companies would certainly join together in deciding what should be considered usual and customary.

It was suggested that when a request of this type is received the Committee obtain the opinion of the specialty society in which sphere the case is involved; and, if the fee is determined to be within the usual and customary or reasonable range for the service rendered, the insurance company should be so notified with the note that the decision can be appealed to the Medical and Chirurgical Faculty. In the event that a fee is flagrantly out of line for the service rendered

the Committee should contact the physician involved with this information.

Donald Pachuta, MD, chairman of the Drug Abuse Committee, presented a report and several recommendations made by his committee. The program outlined is an extensive educational activity which is most impressive. The Committee recommended that the word "Abuse" be dropped from its title as it felt this would "turn off" some of the young people who they are trying to reach. The Board felt that a committee entitled "Committee on Drugs" might be misleading and suggested that the Committee reconsider this recommendation and attempt to formulate a more descriptive title which would be acceptable.

Another recommendation of the Committee was that the Society go on record as supporting the recommendation made in the Second Report of the National Institutes of Health on marijuana that all penalties for the use or sale of marijuana be eliminated. The Board took no action on this recommendation feeling that it was insufficiently informed on the subject and requested that copies of the report be distributed to the members before final action was taken.

The Board approved the recommendation that the Committee arrange a program for one of the general meetings of the Society.

The Board commended Dr. Pachuta and his committee for its obvious enthusiasm and the dynamic approach it has taken to alleviate this problem and urged that it submit a budget for the educational activities planned.

In the absence of the treasurer, Philip Wagley, MD, reported that the Finance Committee had met with representatives of several bank trust departments and a brokerage firm in the city to discuss possible means of investing Society funds. No decision has yet been reached by the Committee and there is presently no recommendation to the Board in this regard.

Dr. Wagley also reported that while he was president of the Society letters had been sent to large metropolitan area medical societies throughout the country to ascertain interest in holding a meeting of the officers of these organizations to exchange ideas. The response indicated that there was much interest. Presently, under the Policy and Planning Committee, a proposal is being made to hold such a meeting, possibly during the AMA convention in San Francisco in June. A motion was made and approved that the Board supports this idea and the Committee is urged to continue with its plans.

The Board was informed by Dr. Wagley that presently there is no means by which tax-deductible contributions can be made to the Society for philanthropic enterprises. It was decided to request the Society's legal counsel to draw up articles of incorporation which would allow for such contributions to be made to support educational programs of the Society.

A motion was then made and approved:

"That the Board of Directors commends Dr. Philip Franklin Wagley for the effort he has put forth in the past two years in guiding this Society into a cohesive and purposeful organization."

The following recommendations from the Policy and Planning Committee were accepted by the Board:

"That the president of the Society utilize fully the services of the Society's representatives to the Council and Policy and Planning Committee of the Medical and Chirurgical Faculty by requiring frequent oral reports be given to the Board of Directors by these representatives.

"That the president be urged to utilize the list of new members who volunteer their services for committee work and that these members should be incorporated in the committee activities as rapidly as possible.

"That the Board of Directors appoint some to sit on the health committee of the Cylburn Park-Cold Spring Lane Community Organization."

These recommendations are made to establish policy for the Society and are not intended to be a criticism of the present working relationships in the organization.

The Board approved the recommendation that the Society place a sign outside the building at 1211 Cathedral St indicating that the headquarters of the Baltimore City Medical Society is located there.

A motion was made and approved that the Society become a member of the Baltimore Council for International Visitors and support this organization in its efforts to orient foreign interns and residents who come to Baltimore.

The Board approved the recommendation of the Medical Care Committee that the National Health Service Corps be requested to assign personnel to the O'Donnell Heights project operated by Baltimore City Hospitals.

The subject of the lack of emergency house call facilities in the city was briefly discussed and it was agreed that a committee be formed to investigate the various mobile medical units in operation throughout the country providing house call services with the view of sponsorship by the Society of such a service.

The Membership Committee is to be requested to consider the possibility of including in the Bylaws some form of membership for medical students.

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Baltimore Nurses Exchange ... 81

Beecham-Massengill Pharm. ... 77, 79, 81

Burroughs Welcome Co. ... 2, 37

Campbell Soup ... 47

Capital Savings & Loan Association ... 70

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Connecticut Mutual Life Insurance Co. ... 10

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Franklin Uniform Co. ... 75

Geigy Pharmaceuticals ... 1, 90-91

Herget & Co. ... 87

Eli Lilly & Co., Inc. ... 54

Lucas Bros. ... 45

Maryland National Bank ... Cover 3

Med-Chi Dirctory ... 45

Merck, Sharp & Dohme ... 35-36

North American Liquidators ... 99

Pharmaceutical Mfrs. Assoc. ... 51-53

Wm. P. Poythress Co., Inc. ... 3, 4

Professional Management, Inc. ... 22

Geo. Radebaugh & Sons ... 15

Read's Drug Stores ... 12

Realty Enterprises ... 99

Reed & Carnrick ... 92

Roche Laboratories ... Cover 4, 6-7, 40-41, 88-89

Russel, Marsh & Kennedy, Inc. ... 9

Sakura Palace ... 40

Manual Schwartz Hearing Rehabilitation ... 70

G. D. Searle Co. ... 48-50

Security Business Services, Inc. ... 15

Special Diet Shop ... 81

Sterling Lighting Co. ... 81

Stuart Pharmaceuticals ... 38-39, 71

Therapeutic Appliances ... 12

Tio Pepe Restaurant ... 33

Upjohn Co. ... 24-26

Van Dyke & Bacon ... 70

Winthrop Labs. ... 72-74

Warner-Chilcott Labs. ... 22-23

D. Stuart Webb Advertising Services, Inc. ... 81

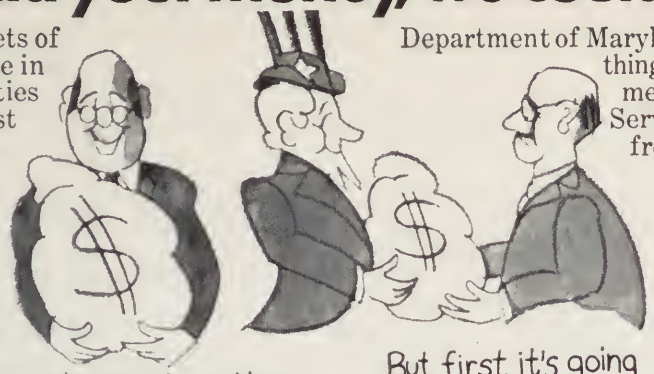
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Vera Woods Personnel Service ... 96

Zimmermann's Shoes ... 12

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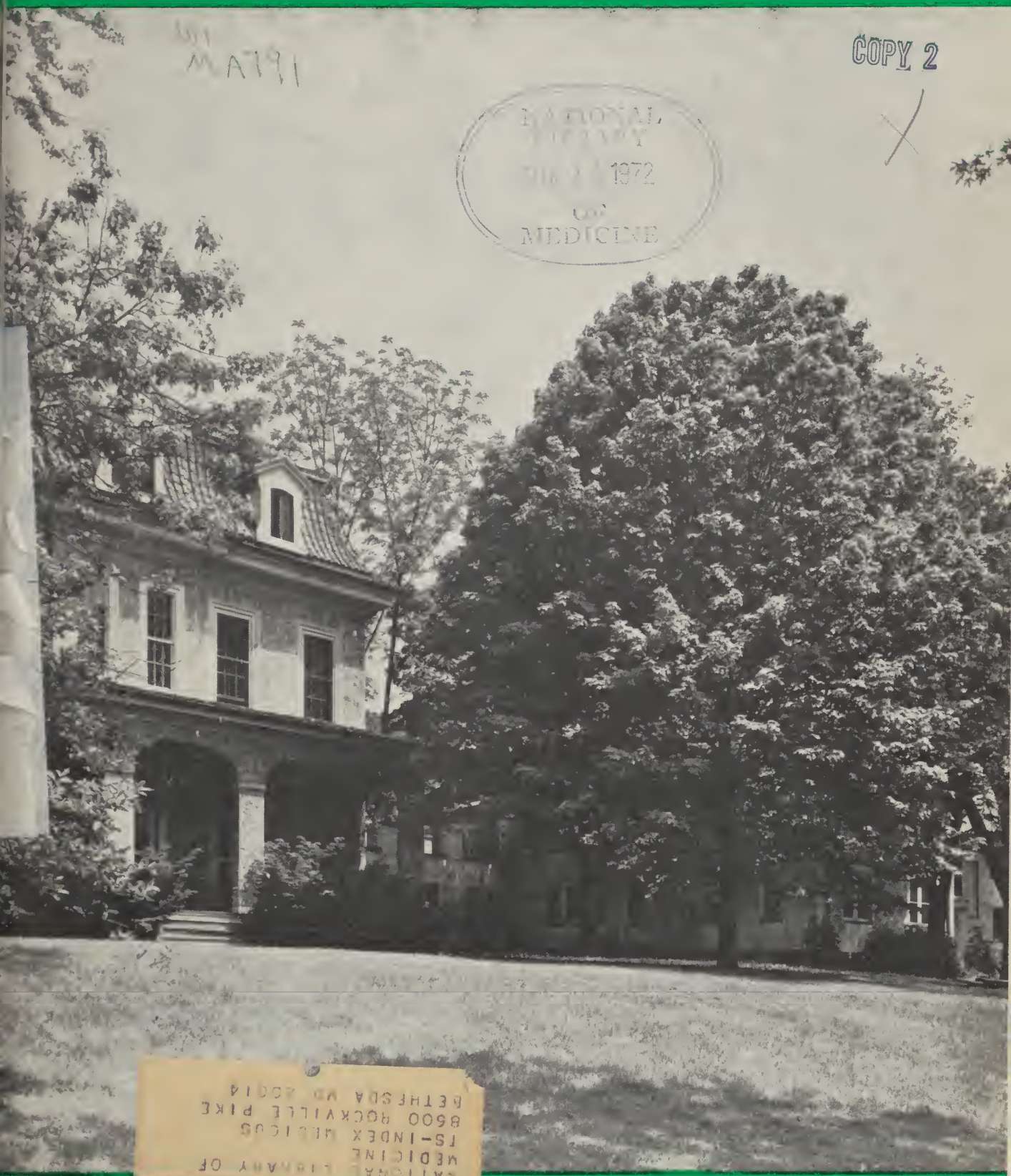
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VOLUME 21 JULY 1972 NUMBER 7


## ARTICLES:


**Medical Education in Maryland in the Eighteenth Century**—Douglas Carroll, MD ..... 49

**Community Mental Health and the Mentally Ill Offender**—John Goldmeier, PhD; Elizabeth G. Patterson, MSW; Robert H. Sauer, MD ..... 56

**Socio-economic Correlates of Tetanus Immunization**—T. J. Craig, MD; C. Anello, ScD; G. W. Comstock, MD; H. J. Garber, MD ..... 60

**Child Neglect and Abuse**—Joseph James, Jr. ..... 64

**Initial Management of the Multiply-Injured Person**—Constantinos P. Chilimindris, MD ..... 66


## DEPARTMENTS:


**Your Medical Faculty at Work**—John Sargeant ..... 6

**Woman's Auxiliary—Newest Member, Anne Arundel** ..... 14

**Maryland Medical Political Action Committee—Introducing Dr. Markley** ..... 18

**Baltimore City Health Department—Iron-enriched Milk Program** ..... 30

**Heart Page—Antimicrobic Prophylaxis Against Infective Endocarditis**—Michael L. Levin, MD ..... 38

**Rehabilitation Medicine—Calcinosis Universalis**—Faton Gashi, MD; Margaret M. Kenrick, MD ..... 73

**Library—Library Bylaws 1848, 1972; New Accessions** ..... 83

**Alcoholism Section—Alcohol-Related Illnesses** ..... 89



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## MISCELLANY:


Doctors Take Note 8
Med-Chi Presidents 9
Director's Newsletter 11
Doctors in the News 15
Scientific Exhibits 17
Semiannual Meeting 19
Component Societies 25, 28
Open Forum 26
Book Reviews 27
Medical News Briefs 32, 94
Dr. Singewald Award 36
Info. for Authors 96
Classified Advertising 97
Advertising Index 98

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*Adverse Reactions:* Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
(B)98-146-103-C

*For complete details, including dosage, please see full prescribing information.*

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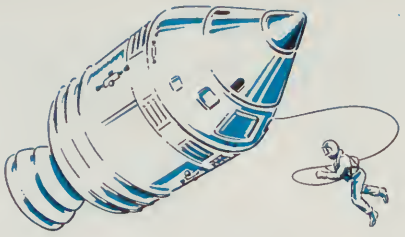
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*Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.*

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Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

**Dosage:**

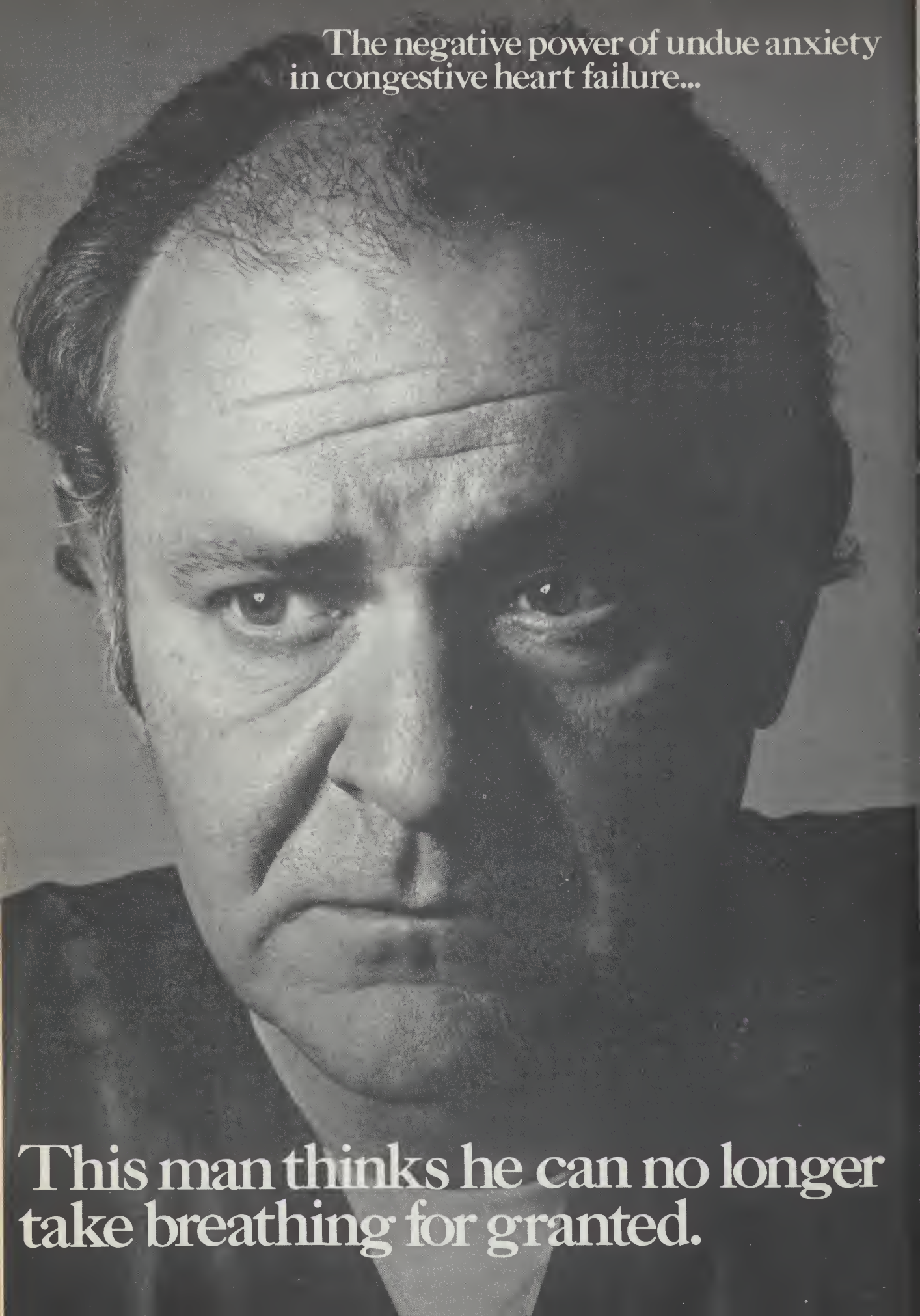
*For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.*

*2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.*

*A clinical supply will be sent to physicians and hospitals on request.*

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Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

*Concomitant use with primary agents*

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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up to 100 mg daily

## for severe anxiety accompanying congestive heart failure

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# your medical faculty at work

**by John Sargeant, Executive Director**

**The General Membership of the Faculty met on Thursday, May 4, 1972 at the Baltimore Civic Center and elected the following to membership on the Board of Medical Examiners:**

Archie R. Cohen, MD, Clear Spring (June 1972-1976)
Karl F. Mech, MD, Baltimore (June 1972-1976)
John F. Schaefer, MD, Baltimore (June 1972-1974)

**The Council met on Wednesday, May 3, at the Baltimore Civic Center and took the following actions:**

1. Waived dues on account of illness for the 1972 year for a physician member.
2. Approved recommendations to the House of Delegates for Emeritus Membership of certain members on the request of their component society.
3. Agreed to endorse the Ad Hoc Committee on a New Faculty Building report and recommend its approval to the House of Delegates.
4. Recognized the O'Donnell Heights area in Baltimore City as having an acute shortage of physicians. Such action clears the way for assignment of National Health Service Corps personnel to this area.
5. Authorized payment of legal fees in an instance of legal defense with the understanding that no further obligation exists on the part of the Faculty in connection with an appeal being made in this matter.
6. Elected Manning W. Alden, MD, Annapolis, as Chairman of the Council for another year; and elected William G. Speed, III, MD, Vice Chairman of the Council.

**The House of Delegates at the annual session held on Wednesday, May 3, at the Baltimore Civic Center, took the following actions:**

1. Received the minutes of the Semiannual session held in Baltimore, on Saturday, Sept. 11, 1971.
2. Heard greetings from neighboring state medical society presidents.
3. Presented 50-year pins and certificates to the following members:
   J. Morris Reese, MD, Lutherville
   William D. Noble, MD, Easton
   and instructed that certificates for the following members be mailed to them:
   Leo Brady, MD, Scottsdale, Arizona
   Samuel Whitehouse, MD, Baltimore
   Leslie E. Daugherty, MD, Cumberland
4. Elected the following to Emeritus Membership in the Faculty:
   Emmanuel A. Schimunek, MD
   Jacob M. Miller, MD
   Helen B. Taussig, MD
   James A. McCallum, MD
   James K. Insley, MD
   all of Baltimore; and
   William S. Murphy, MD, Rockville
   Robert S. Bier, MD, Silver Spring
5. Received the 1972 budget as approved by the Council.
6. Heard that the Faculty's books had been audited for 1971 and that this report would be available for the Semiannual meeting.
7. Heard that the Faculty has received contributions for the Grant E. Ward MD Lecture Fund totaling $5,000.
8. Adopted various Bylaw amendments.
9. Adopted a resolution, on recommendation of the Council, that would require introduction

into the AMA House of Delegates by the Faculty's delegates to that session of a resolution calling for the establishment of a study commission to determine the most effective legal way to permit collective bargaining and the institution of class actions on behalf of the medical profession in the United States.

10. Tabled a substitute resolution submitted by the Policy and Planning Committee calling for employment of legal counsel in whose charge would be placed the responsibility for dealing with third-party payment mechanisms under the policy direction of an appropriate committee.

11. Approved purchase in the Faculty name of at least ten but not more than 20 acres of land at the conflux of Routes 29, 40, and 70N located in Howard County, with the exact location of the land to be determined in negotiation with the principals at a price of $10,000 per acre.

12. Heard Robert B. Hunter, MD, of the State of Washington, a member of the AMA Board of Trustees, discuss current AMA policies and offer to answer questions members might have.

13. Adopted a motion urging the Governor to veto House Bill 573, the drug substitution bill adopted by the 1972 General Assembly.

14. Elected the following slate of officers for the terms shown:

*President-elect*
William Carl Ebeling, MD, Towson (President-elect 1972-73 / President 1973-74)

*First Vice President*
Carolyn H. S. Pincock, MD, Silver Spring (1974)

*Second Vice President*
Manning W. Alden, MD, Annapolis (1974)

*Third Vice President*
William G. Speed, III, MD, Baltimore (1974)

*Secretary*
William A. Pillsbury, MD, Timonium (1974)

*Treasurer*
Karl F. Mech, MD, Baltimore (1974)

*Councilors*

*Central District*
Robert B. Goldstein, MD, Baltimore (1976)
D. Frank Kaltreider, MD, Baltimore (1976)
Donald J. Roop, MD, Towson (1976)
John O. Sharrett, MD, Baltimore (1976)
Philip F. Wagley, MD, Baltimore (1976)

*Eastern District*
Arthur T. Keefe, Jr., MD, Chestertown (1976)

*South Central District*
Charles H. Ligon, MD, Sandy Spring (1976)
Marvin I. Mones, MD, Silver Spring (1976)
Carolyn H. S. Pincock, MD, Silver Spring (1972-73)

*Delegate to the American Medical Association*
Russell S. Fisher, MD, Baltimore
(Jan 1, 1973 – Dec 31, 1975)

*Alternate Delegate to the American Medical Association*
M. McKendree Boyer, MD, Damascus
(Jan 1, 1973 – Dec 31, 1975)

*Committee on Program and Arrangements*
John H. Tuohy, MD, Bethseda (1972-76)
Laurence R. Gallagher, MD, Columbia (1973-77)

*Library and History Committee*
Roland T. Smoot, MD, Baltimore (1973-78)

*Finney Fund Committee*
James P. McCarrick, Rockville (1973-78)

# Doctors take note...

## MARYLAND AREA MEETINGS

Aug 1-3 — **US Civil Service Comm** Seminar on ADP in Med for Admin Personnel, Washington. Contact: ADP Mgt Trng Cen, US Civil Ser Comm, Washington DC 20415. Phone (202) 632-5650.

Aug 26-27 — **American College of Surgeons, Maryland Chapter,** Sheraton Motor Inn, Fredericksburg Va. Contact: Elliott R Fishel MD, 338 W Pratt St, Baltimore Md 21210.

Aug 27 - Sep 2 — **Joint International Transfusion Congress,** Washington. Sponsors: Amer Assoc of Blood Banks & International Society of Blood Transfusion. Contact: Transfusion Congress, AABB, Suite 401, 915 19th St, Washington DC 20006.

Oct 8-26 — **Sixth Postgraduate Medical Seminar Cruise.** Teaching cruise sponsored by Georgetown Univ School of Med. Aboard M/S Hamburg. Calls at ports in Italy, the Riviera, Greek Islands, & Russia. Contact: Seminar Cruise, Allen Travel Service, 565 Fifth Ave. New York NY 10017.

## OBSTETRICS & GYNECOLOGY

Aug 9-13 — **Fifth Anl Seminar in Ob-Gyn**, Lake Arrowhead Calif. Contact: Center for Health Sciences, UCLA School of Med, Los Angeles Calif 90024.

Aug 24-26 — **Postgraduate Ob-Pediatric Seminar,** Hollywood Fla. Contact: Bureau of Maternal & Child Health, Div of Health, State of Florida, Box 210, Jacksonville Fla 32201.

## MISCELLANEOUS MEETINGS

Aug 7-10 — **American Health Congress-72,** Chicago. Sponsors: Amer Hosp Assoc, Catholic Hosp Assoc, Amer Nursing Home Assoc, Health Industries Assoc. Contact: Amer Health Congress, 840 N Lake Shore Dr, Chicago Ill 60611.

Sep 5-9 — **XII Congress of Internal Med, Boston.** Sponsor: International Society of Internal Med. Contact: Thos A Warthin MD, Gen Chmn, XII International Congress of Internal Med, 4200 Pine St, Philadelphia Pa 19104.

Sep 6-8 — **10th Cancer Chemotherapy Conf**, Madison Wisc. Sponsor: Div of Clinical Oncology, Univ of Wisconsin. Contact: G Ramirez, MD, 714-C, University Hospitals, 1300 University Ave, Madison Wisc 53706.

Sep 11-12 — **32nd Anl AMA Congress on Occupational Health,** Chicago. Contact: H F Howe MD, AMA, 535 N Dearborn St, Chicago Ill 60610.

Sep 12-15 — **3rd Conf on Computer Applications in Radiology,** Med Cen of Univ of Missouri at Columbia. Fee $80. Contact: J L Mowrer, Conf Section, Continuing Med Educ, M-175 Med Cen, Columbia Mo 65201.

Sep 24-28 — **American Academy of Ophthalmology & Otolaryngology,** Anl Mtg, Dallas. Contact: C M Kos MD, AAOO, 15 Second St SW, Rochester Minn 55901.

Oct 2-6 — **American College of Surgeons**, 58th anl clinical congress, San Francisco. 16 postgraduate crs. Open to all drs. Contact: ACS, 55 E Erie St, Chicago Ill 60611.

Oct 9-11 — **American Electroencephalographic Society,** continuation crs on Clinical Electroencephalography, Houston. Contact: Donald W Klass MD, EEG Crs Dir, Mayo Clinic, Rochester Minn 55901.

Oct 14-20 — **Anl Otolaryngologic Assembly of 1972**, Eye & Ear Infirmary, Univ of Illinois Hosp. Sponsor: Dept of Otolaryngology, Abraham Lincoln School of Med, Univ of Illinois. Contact: OTOLARYNGOLOGY, PO Box 6998, Chicago Ill 60680.

Oct 16-20 — **American Assoc for Laboratory Animal Science**, 23rd Anl Session, St. Louis. Contact: Joseph J Harvey, AALAS, PO Box 10, Joliet Ill 60434.

Oct 19-21 — **American College of Gastroenterology,** Anl crs in postgraduate Gastroenterology, Montreal. Also 37th anl conv Oct 16-18. Contact: ACG, 299 Broadway, New York 10007.

# MED-CHI PRESIDENTS — PAST AND PRESENT



CHANGE OF COMMAND—With the passing of the gavel from John F. Schaefer, MD, Baltimore, right, to DeWitt E. DeLawter, MD, Bethesda, Dr. Schaefer concluded his term as Faculty president. The scene was at the Presidential Banquet at the 174th Annual Meeting on May 4.



PAST PRESIDENT—Henry A. Briele, MD, Salisbury, right, 1970-71 Faculty president, accepts the past president's plaque from Dr. Schaefer, 1971-72 president of the Medical and Chirurgical Faculty. This presentation was also made at the Presidential Banquet in May.

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# executive director's newsletter

July 1972

**COMMITTEE APPOINTMENTS**

There has been an excellent response to the cards sent all members regarding their wishes to serve on Faculty committees. As many requests as are possible are being compiled with. However, it is not possible to honor all the requests received.

The interest of the membership, as evidenced by the response, is most appreciated.

**DISPOSAL OF DRUG SAMPLES**

Once again, police and drug authorities are bringing to the Faculty's attention that a prime source of drug abuser's supplies is the unwanted discard of drug samples physicians dispose of in their trash.

Physicians (and their office help) are urged to dispose of unwanted samples by accumulating them and dropping them off at the Faculty office for shipment by the Auxiliary to undeveloped countries, or by disposing of them by means other than discard in the trash.

**SMALLPOX IMMUNIZATIONS**

While state law has been changed to eliminate the requirement for smallpox immunization prior to entering school, there is nothing to prohibit physicians from continuing to give such immunizations. Some confusion has arisen in connection with travelers to foreign countries who have requested such immunization from physicians.

Immunization is not required to re-enter the United States unless the traveler has visited an area where smallpox is endemic. In addition, some countries still require immunization prior to entering.

**ANNUAL REPORTS**

Look for the Annual Reports in the August issue of the Maryland State Medical Journal. Delegates and those planning to attend the semiannual session in Ocean City should bring this issue of the Journal with them. Reprints of the reports will not be available.

**RESOLUTIONS FOR SEMIANNUAL**

Resolutions for the semiannual session of the House must be received in the Faculty office by Friday, July 21, 1972, in order to be in conformance with Faculty Bylaws.

A date for the Reference Committee meeting has not been set as yet.

'ARLIAMENTARY PROCEDURE

An instructional session on Parliamentary Procedure has been approved by the Executive Committee. It will be conducted by William J. Evans, Esq., Faculty Parliamentarian, and will be held from 8:30 AM to 9:30 AM, just prior to the House of Delegates meeting in the Ocean City Convention Hall.

A continental breakfast will be served at 7:45 AM. Reservations are required. Details will be in the mail to all members shortly.

)ELEGATIONS OF )UTIES BY PHYSICIANS

House Bill 468, now signed into law by the governor takes effect on January 1, 1973. This will permit physicians to delegate duties to persons qualified to perform some procedures now defined as the Practice of Medicine.

The Board of Medical Examiners is currently developing regulations in this regard. Interested physicians should provide suggestions or data that would be helpful to the Board in implementation of this bill's intent.

:EVISED PUBLICATIONS

Available shortly after July 1, 1972, will be newly revised publications as follows:

LAWS, RULES AND REGULATIONS WITH WHICH PHYSICIANS MUST COMPLY

COMPENDIUM OF DECISIONS (OF THE FACULTY) DEALING WITH ETHICS, PROPRIETY AND LEGALITY GOVERNING THE PRACTICE OF MEDICINE IN MARYLAND

Requests for copies should be addressed to the Faculty office.

John Sargeant

Executive Director

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# OUR NEWEST MEMBER, ANNE ARUNDEL

A happy coincidence is the organizing of our twelfth county in the same year that our national auxiliary is celebrating its fiftieth anniversary. We feel this is a fitting tribute to our national society and an omen of good luck to our twelfth component auxiliary, Anne Arundel County.

The beginnings were casual enough. A group of 15 Members-At-Large met at a morning coffee in the fall of 1971. Someone suggested it would be nice if Anne Arundel had its own auxiliary. From this, ideas and action flew apace.

By the end of January 1972, they were ready for formal organization and Members-At-Large Chairman Mrs. Sergio Alvarez called the state auxiliary president requesting that a letter asking permission to organize be sent to the president of the Anne Arundel Medical Society, C. R. MacDonald, MD. The letter was sent and permission received. After a few more meetings and a great deal of work on the part of Mrs. Alvarez, the twelfth county auxiliary was formally installed on April 11, 1972.

There were 22 doctors' wives present in this charter group. Eleven were new members and 11 were Members-At-Large from Anne Arundel County. Officers elected and installed were:

President,
Mrs. Sergio Alvarez

President-elect,
Mrs. Febus Grunberg

Vice President,
Mrs. Martin Berger

Corresponding Secretary,
Mrs. Jack I. Stern

Recording Secretary,
Mrs. Renato Tuico

Treasurer,
Mrs. Ryun H. Kim

Assistant Treasurer,
Mrs. Robert D. Kabo

Parliamentarian,
Mrs. Benj. A. DeGuzman

Mrs. Reiter, state president, conducted the installation; Mrs. Kolkin, state president-elect, talked about Auxiliary aims and projects for the coming year; Mrs. Sullivan, state treasurer, explained dues and charter memberships; and Mrs. Stone, state parlimentarian, outlined basic rules of parlimentiary procedure.

This historic meeting took place at a morning coffee held at the home of Mrs. Febus Grunberg in Bowie, Md, with Mrs. Alvarez presiding. The meeting adjourned at noon.



Mrs. Alvarez

●

**Robert W. Gibson,** MD, has been elected president of the Central Neuropsychiatric Hospital Association. Dr. Gibson is medical director of The Sheppard and Enoch Pratt Hospital in Towson. Incidentally, Dr. Gibson advises that Sheppard Pratt has been designated as a US Historical Landmark.

●

Three Sheppard Pratt psychiatrists participated in a recent lecture series at the Howard Community College on "The Generation Gap." They were **Emilio Dominguez,** MD; **Robert N. Olson,** MD; and **James J. Gibbs,** MD.

# Doctors in the News

**Charles B. Payne,** MD, has been appointed chief of internal medicine at Baltimore's Provident Hospital.

He comes to Baltimore from Cleveland where he is senior clinical instructor in medicine at Case-Western Reserve School of Medicine, is in private practice, and on the staffs of several hospitals.

Dr. Payne received his BA from Yale in 1952 and his MD from the University of Pennsylvania in 1956.

•

Among those elected to the Board of Directors of the Association for the Advancement of Medical Instrumentation at their recent annual meeting in Las Vegas was **Herbert Ley,** MD, Bethesda. He will serve a three-year term.

AAMI also announces the relocation of its headquarters office to 1500 Wilson Blvd, Suite 417, Arlington Va 22209 from Bethesda Md.

•

The first recipient of the Mental Health Association Research Achievement Award is **Seymour S. Kety,** MD, of Harvard University. The presentation was made on May 3 by Elliott Richardson, DHEW secretary.

The award will be made annually in May to the researcher who, in the eyes of the NAMH Research Committee, has made the major contribution to the prevention of mental illness.

Dr. Kety was in Maryland in 1961-1962 at The Johns Hopkins School of Medicine where he served as psychiatrist-in-chief.

•

**Donato J. Alamprese,** MD, of the attending staff of St. Agnes Hospital, Baltimore, has been reelected president of The National Guild of Catholic Psychiatrists.

•

**Leo H. Bartemeier,** MD, Baltimore, assumed the presidency of the American College of Psychoanalysts at the annual meeting in Dallas on April 30.

An internationally recognized leader in psychiatry and psychoanalysis, Dr. Bartemeier climaxes a long and distinguished career with the presidency of this national honorary organization.

Among numerous past honors, he has served as president of the American Psychiatric Association, American Psychoanalytic Association, and International Psychoanalytic Association.

He succeeds another Maryland psychoanalyst, **Henry P. Laughlin,** MD, Bethesda, who had served as president of the College since its inception.

He has also served as president of the American College of Psychiatrists and of the Eastern Psychoanalytic Association.

•

**Richard E. Hoover,** MD, chief of ophthalmology at the Greater Baltimore Medical Center, is serving on an American Foundation for Overseas Blind (AFOB) scientific and medical advisory committee which is undertaking a nutritional program designed to prevent eye disease among preschool children in underprivileged countries.

•



Dr. Garrison

**Alfred S. Garrison,** MD, has been appointed chairman of the Department of Surgery at Baltimore's St. Agnes Hospital where he had been serving as acting chairman since last August.

In this full-time capacity, Dr. Garrison is responsible for the administration of the Department of Surgery and for maintenance of the surgical education program.

A Catonsville native, he received his BA from Western Maryland in 1939 and his MD from the University of Maryland School of Medicine. He completed his residency in surgery at St. Agnes.

•

The American Society of Anesthesiologists (ASA) reports three Marylanders are among a group of doctors recently certified as ASA Fellows. They are:

**Gary J. Healy,** MD, Suitland;

**Kwang Won Kang,** Havre de Grace; and

**Wayne K. Thorpe,** Bethesda.

•

**Lewis E. January,** MD, professor of medicine at University of Iowa Hospitals, received the **Helen B. Taussig** award at the annual meeting of the Central Maryland Heart Association on June 6.

The award is named for Dr. Taussig, a former president of the American Heart Association, and professor emeritus at The Johns Hopkins Hospital.

●

**George G. Finney, Sr.,** MD, associate professor emeritus of surgery at The Johns Hopkins Medical School, has been selected to serve as the first president of the newly merged boards of the United Fund of Central Maryland and the Community Chest of the Baltimore Area. He had been serving on the United Fund Board of Directors.

According to Dr. Finney, the merger will more efficiently utilize the volunteer and staff manpower of the two organizations and is the result of an extensive study conducted last year.

The recent recipient of the Distinguished Service Award of the American College of Surgeons, Dr. Finney was congratulated and commended for that outstanding recognition by Senate Resolution No. 125 on March 14 by the Maryland Senate.

●



CENTURY OF SERVICE—During the House of Delegates session at the 174th Annual Meeting in Baltimore on May 3, 50-year pins and certificates were presented to two Med-Chi members. The awards were made by John F. Schaefer, MD, Faculty president, left, to J. Morris Reese, MD, Lutherville, center; and William D. Noble, MD, Easton, right. Not present, but also receiving similar recognition, were Leo Brady, MD, Scottsdale, Arizona; Samuel Whitehouse, MD, Baltimore; and Leslie E. Daugherty, MD, Cumberland.

Among seven new members elected to the Board of Directors of Maryland Blue Shield are two doctors: **Conrad L. Inman, Jr.,** MD, a Baltimore oral surgeon; and **Richard S. Ross,** MD, Clayton, professor of cardiovascular diseases at Johns Hopkins.

Blue Shield directors serve voluntarily, without compensation, in the public interest.

●

**Louis J. Kolodner,** MD, Baltimore, was a guest in May of Domas Medica of the Royal Society of Medicine in London, where he pursued studies in preparation for a scientific paper.

While abroad, he also visited Guy's Hospital in London and medical colleagues in Naples and Positano, Italy.

●



CANDID CAMERA—On behalf of the medical staff and administration of Bon Secours Hospital, John Sargeant, left, Med-Chi executive director, presented John F. Schaefer, MD, outgoing Faculty president, with a portable TV set at the Presidential Banquet. The note from Frank J. Otenasek, MD, president of Bon Secours' medical and dental staff said, in part: "Just a small token on behalf of Bon Secours to a physician who has devoted his time and energy to advancing the cause of all Maryland physicians. Even more than that, Bon Secours is proud and indebted to you for all the efforts you have extended on our behalf."

# 1972 SCIENTIFIC EXHIBIT WINNERS



**MOST OUTSTANDING**

Judges for the scientific exhibits on display at the 174th Annual Meeting of Med-Chi at the Civic Center in Baltimore May 3-5 again had a hard time in selecting the "best of show." However, they finally settled on the two pictured here.

For the "Most Outstanding," they chose the one with this long title: "Argon Laser Photocoagulation II—Diabetic Retinopathy and Related Vascular Diseases." It was assembled by a team of doctors from the Wilmer Institute of The Johns Hopkins Hospital. Headed by Arnall Patz, it also included A. Edward Maumenee, Howard Schatz, Joseph W. Berkow, and Stephen J. Ryan, Jr.—all MDs.

Retinal photographs show the typical opthalmoscopic findings In diabetic retinopathy and related retinal vascular diseases. The use of the argon laser photo-coagulator in these disorders is demonstrated. A continuous 8-mm movie shows the actual firing of the laser and the coagulation response of the vessels when so treated.

As the "Most Innovative," the entry submitted by J. C. Childers, Jr., MD, Baltimore, won out over spirited competition. Dr. Childers called his exhibit: "Arthroscopy: A New Tool for Diagnosis of the Problem Knee."

His exhibit consisted of a coordinated sound-slide presentation describing the use, advantages, and limitations of the technique of direct visualization of intra-articular lesions of the knee through an arthroscope. Representative slides of common lesions, as well as some of interesting, uncommon lesions, were presented and described on a self-repeating tape.

It's not too early to start planning your exhibit for the 1973 Annual Meeting although rules and enrollment forms will not be available for several months.




**MOST INNOVATIVE**

Maryland Medical Political Action Committee

RAYMOND L. MARKLEY, MD, Chairman

MRS. FRANCIS C. MAYLE, Editor

# INTRODUCING RAYMOND L. MARKLEY, MD

Dr. Markley is the new chairman of the Maryland Medical Political Action Committee. He replaces DeWitt DeLawter, MD, who is, of course, the new president of the Med-Chi Faculty.

An MMPAC member since 1946, Dr. Markley was treasurer from 1965 to 1969 and newsletter editor from 1969 to 1971. He is a gynecologist and is actively engaged in the practice of gynecology and female urology in Baltimore. His appointments include: assistant in the Department of Obstetrics and Gynecology, University of Maryland School of Medicine; consulting gynecologist, University Hospital, Maryland General Hospital, Bon Secours Hospital, and The Hospital for the Women of Maryland.

He received his MD from the University of Maryland School of Medicine in 1946 and interned at Bon Secours Hospital. He served three years as a Captain in the Army Medical Corps and was Resident in Obstetrics and Gynecology at The Hospital for the Women of Maryland from 1950 to 1954. He has contributed a number of articles to professional journals.

Dr. Markley is married and has a 14-year-old daughter and a 10-year-old son. His wife, Doris, who is a past president of the Baltimore City Woman's Auxiliary, raises Standard White Poodles.

Dr. Markley is a member of the American College of Obstetricians and Gynecologists, the American Board of Obstetrics and Gynecology, the Southern Medical Society, the Maryland Medical Society, the Baltimore City Medical Society, and the Maryland Obstetrical and Gynecological Society.

He and his son are active in the YMCA Indian Guides and he is Chief of the Tonto Tribe, proudly claiming the Indian name of Big Wild Horse.

The doctor is a member of Ascension Lutheran Church in Towson and an active Church Council member. His wide-ranging interests also include the Johns Hopkins Club, the Maryland Historical Society, Self Defense training at the YMCA for which he won an award in 1970, and the Ice Club of Baltimore. He is a Son of the American Revolution and a member of the Board of Managers of that group, and also a member of the Professional Forum.



Dr. Markley

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- In 1940 less than one person out of ten in the United States had private health insurance protection.
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—Health Insurance Institute

# SEPTEMBER 14, 15, 16, 1972

*IT'S OCEAN CITY AGAIN-BY POPULAR DEMAND FOR*

# SEMIANNUAL MEETING

**MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND**

A program of continuing medical education combined with fun and relaxation for all physicians and their families.

**SCIENTIFIC SESSIONS – CONVENTION HALL**

FRIDAY, SEPTEMBER 15 – Session cosponsored by Maryland Radiological Society

*ALL PHYSICIANS INVITED TO ATTEND THIS PROGRAM OF GENERAL INTEREST*

2:00 to 3:30 PM–*THE ROLE OF CORONARY ARTERIOGRAPHY IN THE DIAGNOSIS AND TREATMENT OF CORONARY DISEASE*

**Herbert L. Abrams, MD,** Cook Professor and Chairman of the Department of Radiology, Harvard Medical School

*PANEL DISCUSSION* to follow *including*

**Vincent L. Gott, MD,** Richard Bennett Darnall Professor of Surgery, The Johns Hopkins University School of Medicine

**Leonard Scherlis, MD,** Professor of Medicine and Head, Division of Cardiology, University of Maryland School of Medicine and *moderated by*

**John B. Hearn, MD,** Department of Radiology, St. Joseph Hospital, Towson, Md

This discussion will concern itself chiefly with the indications and usefulness of *BYPASS SURGERY* in coronary diseases.

SATURDAY, SEPTEMBER 16

10:00 AM–*ADVANTAGES AND DISADVANTAGES OF NEUROLOGICAL CONTRAST STUDIES*

**John O. Sharrett, MD,** Instructor in Neurosurgery at the University of Maryland School of Medicine

11:00 AM–*MEDICAL MALPRACTICE: NO FAULT OR OUR FAULT*

A panel discussion presented by the Committee on Medical Economics of the Medical and Chirurgical Faculty

Moderator: **W. Kenneth Mansfield, MD,** Chairman of Committee

Participants: **John F. King, Esquire**
**Jonas R. Rappeport, MD,** Psychiatrist for Supreme Bench of Baltimore
**George McGowan,** Claims Representative, St. Paul Insurance Company

**BUSINESS SESSIONS** – CONVENTION HALL

THURSDAY AFTERNOON, SEPTEMBER 14,–MEETING OF THE FACULTY COUNCIL

FRIDAY MORNING, SEPTEMBER 15–MEETING OF THE HOUSE OF DELEGATES

**SOCIAL FUNCTIONS**

FRIDAY EVENING, SEPTEMBER 15,–CONVENTION HALL

**RECEPTION AND DINNER** with special entertainment

SATURDAY, SEPTEMBER 16 – 1:00 PM – The ever-popular crab feast will be held at **Phillips Crab House**

**WOMAN'S AUXILIARY**

FRIDAY MORNING, SEPTEMBER 15–Meeting at Convention Hall

**HOTELS AND MOTELS**

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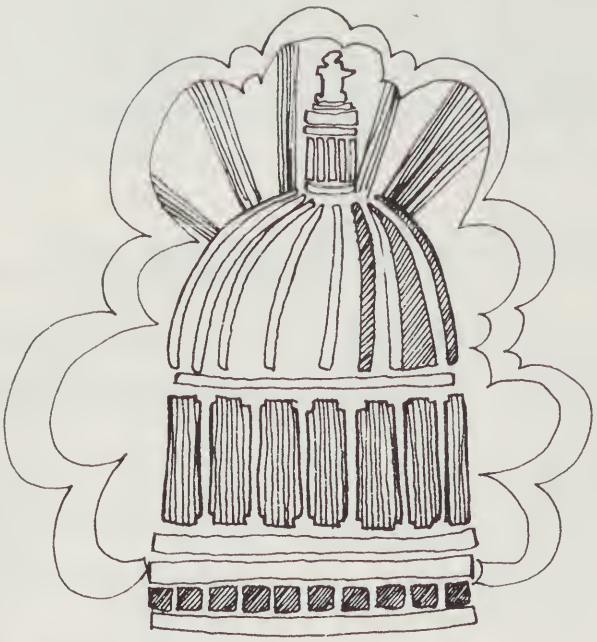
Castle in the Sand – 37th Street and Ocean
Gateway – 48th Street and Ocean
Harrison Hall – 15th Street and Boardwalk
Park de Ville – 55th Street and Ocean
Kittiwake – 45th Street and Ocean
Stardust – 32nd Street and Ocean
Surf and Sand – 23rd Street and Boardwalk
Quality Court – 17th Street and Boardwalk
Beach Plaza Hotel – 13th Street and Boardwalk
Commander Hotel – 14th Street and Boardwalk

*NO ENDORSEMENT OF THE ABOVE IS IMPLIED*

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**SEPTEMBER 14, 15, 16, 1972**

Albert M. Antlitz, M.D. Chairman
Committee on Program and Arrangements



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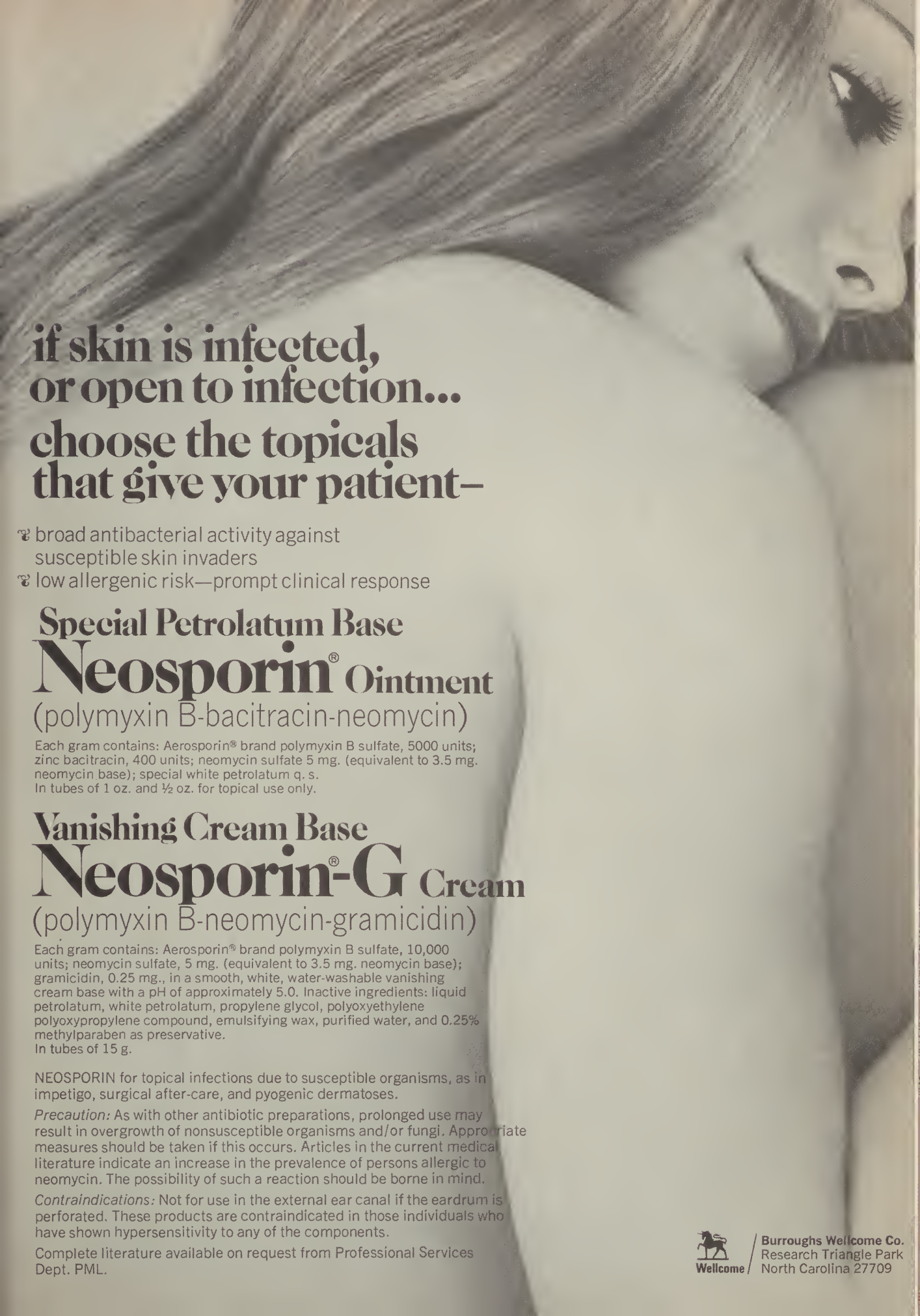
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# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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# BALTIMORE COUNTY MEDICAL ASSOCIATION

The March meeting of the Baltimore County Medical Association was held at the Carney Crab House on March 15. The meeting was called to order by the president, Herbert Levickas, MD.

Dr. Levickas welcomed the members and introduced two new members: Carol Posner, MD, and Arthur Jasion, MD.

The minutes of the previous meeting were approved and the treasurer, Dr. Riley, reported finances in good order.

## Committee Reports

**Program** — Dr. Velez, program chairman, announced the April meeting would be held at Sheppard-Pratt Hospital; the May meeting at the Flaming Pit in Timonium, a joint meeting with the Auxiliary; and the June meeting at St. Agnes Hospital.

**Board of Governors** — The Board of Governors met on March 8. One of the problems discussed was the Peer Review Committee. There is some consternation within the Board of Governors relative to criticism of some of their decisions. This criticism has come through indirectly to the Peer Review Committee and the Board.

It seems that the state Peer Review Committee is considering cases which should come within our jurisdiction.

The Board feels that county cases should be considered by our own group. If consultation is required, the Board suggested the president write a letter to the Faculty president and make our feelings known. This has been done. On proper motion, the report of the Board of Governors was accepted.

**Medical Legislation** — The president has written letters to the members of the Economic Affairs Committee of the State Legislature concerning the Chiropractic Bill (SB523). The chiropractors desire to have their services covered by Blue Shield. Dr. Levickas suggested everyone contact their Baltimore County senators and delegates in Annapolis.

**75th Anniversary** — The Baltimore County Medical Association will celebrate its 75th anniversary during 1972. Dr. Levickas asked for related suggestions from the members who are asked to contact either Dr. Levickas or Dr. Velez with those suggestions.

A letter was received from a former member, Wilmer Gallagher, Jr., MD, requesting support for Senate Bill No. 266. The Hopkins tumor group wants to use "D" Building at Baltimore City Hospitals for research, but the State will have to provide matching funds if they request federal funds. This bill would provide a grant of $2 million from the State for this cancer research program.

**Memberships** — On proper motion, membership applications were approved for the following MDs: Charles Brown, Anthony Di Paula, Soo Hsa Lee, Jose Morelos, Clayton Moravec, and William Vitale. There being no further business, the meeting was adjourned.

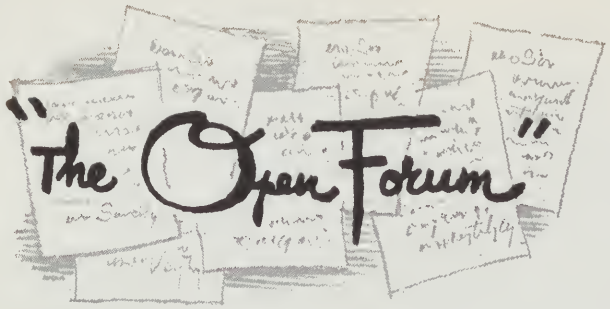
**Committee Chairmen** — Space prevents listing all 1972 committee members, however, a list of committee chairmen (all MDs) follows:

Board of Governors, John Krager; Program and Scientific Work, B. B. Velez; Ethics and Membership, Theodore Patterson; Public Relations, Lester Kolman; Hospital, Medical Care and Emergency Service, Thomas Holcomb; Medical Legislation, J. Morris Reese; Peer Review, Clarence McWilliams; Family Life and Human Development, John Krager; Building, S. J. Venable; and Sports, John Krager.

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# TOO MANY TESTS?

I feel compelled to take issue with Dr. Park Espenschade's reply (p 86, Dec 71) to my letter (p 17, July 71) in this Journal, protesting the overuse of tests, other procedures, and "gadgetry" in our hospitals. I am familiar with the situations which Dr. Espenschade enumerated as contributing to the "proliferation of excessive lab tests" and can and have added others. In fact, I have had several articles on this subject published in national journals.[1, 2] But granted these situations exist, they do not justify a physician's compliance at the expense of his good judgment and clinical acumen. Sound medical practice requires that a physician use discretion in ordering diagnostic procedures with full understanding of the real indications for them.

In making my point, I could have picked overuse of electroencephalography, scintiscanning or augmented types of gastric analyses, routine esophageal biopsies, or any one of a variety of other diagnostic techniques. I singled out gastroscopy as an example because of my familiarity with it and my first-hand knowledge of its abuse. I should point out that Eddy Palmer's contributions (question was raised in Dr. Espenschade's letter) in this field were developed in a military establishment, not at all analogous to the situation in the community hospital. Furthermore, I believe that outstanding physicians with expertise in a particular procedure may tend to use it frequently in a setup which makes it easy to do so. The fact of the matter is that case after case could be documented, if time and space permitted, which could lead to only one conclusion, overusage.

Dr. Espenschade said that in his experience (he graduated in 1962 and was our Resident in Medicine at Union Memorial Hospital in 1969, and I have been doing gastroscopies since 1942), "nowhere enough endoscopies are done, especially in the acute GI bleeder." While I agree that unexplained gastrointestinal bleeding is an indication for gastroscopy, even this view has its dissenters, eg, L. J. Sandlow, MD, of the Medical Reese Hospital and Medical Center, who claims, "no benefits seen in the aggressive diagnostic tack in G.I. bleeding."[3]

In an article entitled "When to Justifiably Use Gastroscopy," I enumerated certain indications, contraindications, and relative contraindications to the use of gastroscopy.[1] Essentially, my point was that gastroscopy should be used when it can reasonably be expected to provide additional information and should be avoided when it can only confirm what is already known. In another article, I stressed the importance of listening to the patient to pick up "The Diagnostic Sentence."[2] This was a good way to practice medicine in Osler's day and it is still basic today despite all the sophisticated technology we have at our disposal.

As a member of utilization committees of two hospitals, I am in position to know that some practitioners are using the gastroscope indiscriminately. I know that in one hospital where there are four competent gastroscopists, one person does unbelievably and countless more gastroscopies than do the other three put together. I know of one general practitioner who has practically every patient scoped, and the endoscopist does them. There are often no symptoms or hardly any, and frequently the patient's admission to the hospital is for an entirely unrelated condition. Why is the procedure done? If a consultation is in order, have it, but a gastroscopy! I hope the day will not arrive when gastroenterologist and gastroscopist are synonymous. It worries me, too, when I hear the facetious remark made that some scopes must have built-in ulcers and built-in esophagitis.

Who is at fault for this overuse? Two people, I believe. First, the physician who orders an unnecessary procedure without understanding the indications and the contraindications for it. Second, the physician who knowingly performs a procedure that cannot contribute additional information.

In reviewing the charts of patients referred for gastroscopy, I cannot help but deplore the number of studies done without sufficient indication and the number which are negative or misleading. I know, for example, of an instance in which a bezoar identified by X-ray was diagnosed as a serious tumor by gastroscopy. At operation, the original X-ray diagnosis was found to be correct. Other diagnoses of pyloric obstruction, carcinoma, ulcer (benign or malignant), and hiatus hernia have not always been accurate. When one thinks of the number of negative gastroscopies, or those done in which misleading information results, one must be

critical and undertake, even demand, reassessment.

Why do so many cases of hiatus hernia need to be studied gastroscopically? Does every X-ray report of hiatus hernia or irritability of the bulb automatically lead to an endoscopic procedure? Is gastroscopy so often necessary to chart the course of subsequent therapy? I know this may sometimes be helpful, but the notes I have read are so stereotyped that they could well have been written without the procedure being done. I know the implications of esophagitis and reflux, but I still doubt that gastroscopy is necessary as often as it is done. I would also question whether gastroscopy need be *the* determining factor in whether or not surgery is done, and I certainly question the authority of the gastroscopist to recommend exactly what type of surgery is to be done.

What I am pleading for is some recognition of the real indications for this procedure. We should not continue to misuse our instruments and our dollars and to abuse the quality of medical care. The state health secretary recently advocated checking to determine whether more services are being provided than are necessary. I am convinced that there are. Also, the president of Maryland Blue Shield has spoken on the subject relating to physicians who order or perform too many tests; some have had to be warned. I believe we should review each other's work constructively, not polemically and not in a way that justifies the term *caveat*. It is the responsibility of all of us to help curtail mounting health costs. And it is a responsibility of the Peer Review Committee, as defined in their objectives, "to promote, develop, and encourage the distribution of medical services by its members to the people of the area at a cost which is reasonable to both patient and physician."

Recently, several articles have appeared as, for example, in the August 1971 issue of *Annals of Internal Medicine* entitled "The Use of the Laboratory in the Teaching Hospital," where it is pointed out that laboratory studies contribute significantly to the cost of hospitalization. One would not believe the number of tests and the proportion of the bill accounted for by these tests during the patient's hospitalization. The question is raised as to how often the result of laboratory tests actually influences diagnostic and therapeutic decisions. Several other articles have recently appeared on the same subject (Editorial, *JAMA* Oct 4, 1971; Editorial, *Annals Internal Medicine,* August 1971; Alvarez, *The Sun* 1/14/72; and others).

More voices need to be raised against the lamentably widespread use of needless and redundant testing. At issue is the rational practice of good medicine with due regard for the cost of providing it. Laboratory tests, endoscopic procedures, and other techniques must be viewed in their proper perspective. In the midst of our enchantment with all the new gadgets, let us not overlook the oldest diagnostic "instrument" of all—the brain. Expressed another way—What we need, at this time perhaps, is less machinery and more humanity.

**References**


1. Morrison S: When to justifiably use gastroscopy. Consultant. March 1968, vol 8, p 26.
2. Morrison S: The diagnostic sentence. Consultant. February 1969, vol 9, p 22.
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SAMUEL MORRISON, MD
11 E Chase St
Baltimore Md 21202





**INTRODUCTION TO NEUROSCIENCE, edited by Jeff Minckler, MD, The C.V. Mosby Co, St. Louis, 1972.**

Fundamental to all the disciplines related to the human nervous system is a solid command of anatomy. The first 11 chapters are directed to this instruction, both in gross and microscopic features. Included also are basic neuroradiology and growth and biometrics, electron microscopy and tissue culture, neurochemistry, electrophysiology, and a review of integrative mechanisms. It is a well-rounded book and has been produced with the core curriculum in mind.

**DIABETES MELLITUS: Diagnosis and Treatment, Vol III, by Stefan S. Fajans, MD, and Karl E. Sussman, MD, prepared under the auspices of the Committee on Professional Education of the American Diabetes Association, 1972.**

These successive volumes serve the purpose of bringing recent advances with regard to diabetes to both the physician and student, and to highlight some differences of opinion in areas of controversy. Several chapters concern or touch upon the recently published University Group Diabetes Program Study dealing with the use of oral hypoglycemic agents. This volume is not meant to replace previous volumes, but to supplement them. This it does well.




FRANCIS X. CARMODY, MD
Journal Representative

**Baltimore City Medical Society**

# BOARD OF DIRECTORS MEETS

**The Board of Directors met on April 11 for its regular monthly meeting and, after the approval of the March 14 meeting, took the following actions:**

Reviewed the agenda of the Annual Meeting of the House of Delegates and discussed appropriate items with the Delegates and Alternates from the Baltimore City Medical Society to the House.

Approved the recommendation from the Drug Abuse Committee that its name be changed to "Committee on Drugs." The charge to the Committee is to consider problems of psychotrophic drug use, abuse, and addiction in Baltimore City.

Supported the concept of the Anonymous Drug Testing Program of the University of Maryland Department of Pharmacology and urged its continued financial support by the Maryland Drug Abuse Administration.

Agreed to request the Editorial Board of the *Maryland State Medical Journal* to allocate monthly space to the Committee on Drugs for the purpose of educating physicians in the various drugs being abused and the most up-to-date information regarding treatment of drug intoxication.

Supported the North Central Baltimore Health Care Corporation in its request for a grant from the US DHEW for the planning of an prepaid group practice in the North Central Baltimore area.

Reviewed a letter from the HARBEL Community Organization indicating that it is investigating the possibility and feasibility of establishing an HMO in that area.

Approved the recommendations of the Finance Committee that the Society sell all bonds held and all shares of Massachusetts Investors Growth Stock Fund and invest the proceeds of these sales along with surplus cash assets available in T. Rowe Price Growth Stock Fund, Inc.

Discussed a letter received from William H. Mosberg, Jr., MD, concerning various problems which the Society should discuss, and suggested that Dr. Mosberg might be interested in joining the Medical Care Committee of the Society to have a more direct means of voicing his opinions.

Discussed information received from Bridge Medical Associates, a group operating in other areas of the country providing a physician in its employ who would make house calls for contracting physicians. The practicing physician would employ Associates to cover his practice and make house calls on his patients. The calls would be made by moonlighting residents or fellows, evidently. It was agreed to write to the hospitals in the City explaining the project and the dangers involved regarding malpractice actions.

Discussed articles of incorporation of a philanthropic organization for the Baltimore City Medical Society and made some suggested changes. The purpose of this organization would be to provide a means by which members of the Society or the general public could make tax-deductible contributions to the foundation to be used for purposes of education of physicians and public and for public health projects.

Reviewed a letter from a member of the Society regarding the use of credit cards for the payment of physicians' fees and agreed to request a review by the Medical and Chirurgical Faculty Mediation Committee of its ruling that this was unethical.

Supported the recommendation of the Environmental Problems Committee that the Society endorse City Council Bill 121 which would impose a tax on nonreturnable beverage containers.

**The Board of Directors met on May 9 and approved the minutes of the April 11 meeting. The following actions were then taken by the Board:**

Considered and made further recommendations for amendments to the proposed bylaws of the Philanthropic Foundation. This will be presented to the membership for consideration at the October general meeting.

Recommended that Emeritus Membership be granted to Walter A. Anderson, MD, who has retired from practice and is ill.

Considered a letter from the Medical and Chirurgical Faculty stating that the Executive Committee declined to provide a sign outside of the building stating that the Baltimore City Medical Society was located at 1211 Cathedral St. It was agreed that a letter would be written stating that the Baltimore City Medical Society would provide the sign and have it erected.

Agreed to form an ad hoc committee of members of the Baltimore City Dental Society and the Baltimore City Medical Society to investigate means of liaison between the two organizations.

Allocated funds to cover expenses for two persons to attend the meeting of metropolitan medical society officers and some sessions of the AMA meeting in San Francisco in June.

Discussed with the chairman of the Peer Review Committee, Philip Whittlesey, MD, various problems which the Committee has encountered. It was affirmed that the Committee draws its authority from and is responsible to the Board of Directors of this Society and that all cases involving physicians in Baltimore City should be referred to the Society for consideration. Agreed to investigate further the circumstances surrounding the refusal of a physician to make his records available to the Committee and the refusal of the Maryland Commission on Medical Discipline to subpoena these records on the request of the Committee.


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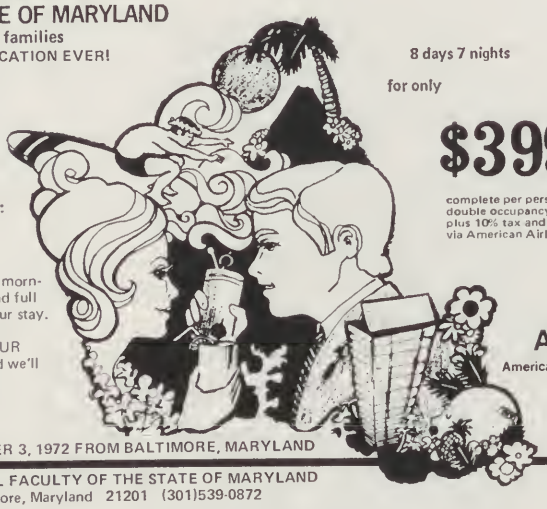
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ROBERT E. FARBER, MD, MPH, Comm.

**Baltimore City health department**

# Baltimore's Iron-enriched Milk Program

A preliminary report submitted on the Cherry Hill iron-fortified milk distribution program by David M. Paige, MD, The Johns Hopkins School of Hygiene and Public Health, provides evidence on the value of the city's special infant feeding programs.

According to Dr. Paige, Cherry Hill babies receiving iron-fortified milk formula are showing significant improvement in height, weight, and blood iron values when these are compared with the established norms for growing children at their respective ages. The babies are checked at birth and at each visit to the Cherry Hill well-baby clinic. Approximately 260 children are in the study group.

At birth 10% of babies were below minimal acceptable weight levels. By the third clinic visit, about six months later, all children had attained normal weight. For height, 20% of babies were below minimal acceptable levels. By the third visit this had been reduced to 5%. With reference to anemia, 40.8% were considered in the below normal hematocrit or blood iron range at birth. When placed on the formula this had been reduced to 13.3% by the third visit and none were considered to be severely anemic.

In the Cherry Hill area Mrs. Doris Lindsay, supervisor of public health nursing for maternity and infant programs, and Mrs. Edia Flippen, public health nutritionist, planned and are directing the community efforts to inform pregnant women that their expected babies are eligible for receiving the iron-fortified formula distributed at the clinic. After the baby arrives, they assist the mother in understanding how to prepare the formula, when and how to begin adding additional foods, and the wise choice of foods for the entire family. A real benefit of this program, which is providing an adequate nutritional start for the infants, will be the effective nutrition education ideas that will provide long-range improvement in family food habits.

Dr. Paige, an international authority on early childhood nutrition, is cooperating with the Baltimore City Health Department in the evaluation of this infant feeding program. He has investigated and contributed to nutrition programs in the United States and in South and Central America.

While the information obtained thus far suggests that Cherry Hill babies are benefiting from the formula program, Dr. Paige indicates that a number of problems must be solved before the infant-feeding program can be termed successful. These are related to 1) the identification of families likely to place a child "at risk" by withdrawing from the program before the baby is nine months old, 2) reinforcing family nutrition education so that the entire family benefits, 3) premature use of cow's milk to the detriment of the baby during its early months of life; and 4) the extension of food supplements beyond the nine-month period. The Health Department is presently assessing these problems and is trying to cope with them.

The iron-enriched milk program for babies was started when Health Department studies found far too many clinic children below the norms for weight, height, and hematocrit. These are some of the main factors which reflect the nutritional status of children.

With Model Cities funding, the iron-enriched formula program was begun first in December 1969 in the Model Cities area. In February 1971, through the assistance of the Maryland Food Committee, the iron-enriched milk formula was made available to Cherry Hill infants and more recently to children in the O'Donnell Heights area.

Baltimore City has come a long way since becoming aware of extensive under-nutrition among inner-city children. Today, principally through

the efforts of the Baltimore City Health Department, the Mayor's Task Force on Nutrition, the City Department of Education, the Maryland Food Committee, and many other interested individuals and groups, there are nutrition programs in Baltimore City directed at infants, preschoolers, school-age children, and the adult population. There is a measure of progress in all of them, but much yet remains to be done by government in financing and developing expanded programs and by individuals and families in applying the principles of good nutrition to themselves.


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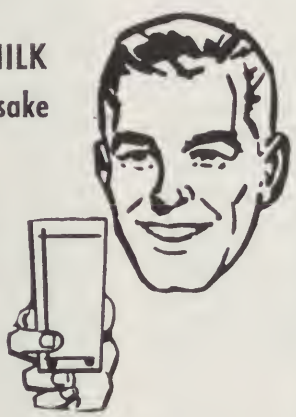
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# MEDICAL NEWS BRIEFS

## Dial The Doctor

"Dial The Doctor" is a medical information line sponsored by The National Foundation-March of Dimes.

Anyone in Maryland can "Dial The Doctor" toll free. This educational program was started last October and has been receiving about 500 calls per month.

In addition to hearing a new message monthly, it is possible for the caller to leave a question related to the topic which will be answered by mail.

As recent examples, the May message dealt with the overwhelming problems of birth defects. John Freeman, MD, director of the March of Dimes Treatment Center at The Johns Hopkins Hospital, was the guest speaker.

The June message concerned "Blood Incompatibility" and "RH Disease."

The number to call is 1-800-492-9502.

## Marino Lecture

F. A. Simeone, MD, professor of medical sciences and surgeon-in-chief, Miriam Hospital, Brown University, delivered the Second Annual Frank C. Marino Memorial Lecture on May 13 at the University of Maryland School of Medicine.

The Marion Lectureship is sponsored by the Department of Surgery of the University of Maryland School of Medicine and Hospital.

Dr. Marino (1894-1965), received his MD from the University of Maryland School of Medicine and was an active surgeon on the staff of many Baltimore hospitals, as well as a leading figure in Baltimore civic affairs. He was founder and first president of Italian-American Charities and was named Italian-American of the Year in 1956.

## Ethnic Diabetic Diets

Seven distinct ethnic diets have been created by USV Pharmaceutical Corporation for use by diabetics. The diets, currently being distributed to physicians nationwide, were prepared by a nutritionist in accordance with current diabetic diet standards.

Foods recommended in the diets are designed to correspond with the cultural food patterns of each ethnic group and are available in most neighborhood supermarkets.

Each diet includes a food exchange list, daily food requirements, and an appetizing sample menu.

The diets represent the most comprehensive effort ever made to help the diabetic patient adjust to the demands of his dietary requirements without giving up goods common to his ethnic background.

To obtain copies of these diets, write Dept. of Nutrition, USV Pharmaceutical Corp, 1 Scarsdale Rd, Tuckahoe NY 10707.

## Thomas O'Neill Labs Dedicated

The Thomas O'Neill Memorial Laboratories of The Good Samaritan Hospital and The Johns Hopkins University School of Medicine were dedicated in special ceremonies recently.

Dedication addresses were made by Robert Q. Marston, MD, director of NIH, and Byron H. Waksman, MD, professor of microbiology at Yale University School of Medicine.

In addition, a host of dignitaries were present and participated in the program.

The laboratories are an organized research unit with primary interest in immmunologic disease. They are staffed by 17 Hopkins faculty members.

The laboratories' units include the Rheumatology Research Laboratory, headed by Mary Betty Stevens, MD; the Clinical Immunology Laboratory, headed by Lawrence M. Lichenstein, MD, the Basic Immunology Laboratory, headed by Kimishige Ishizaka, MD; and the Renal Laboratory, headed by W. Gordon Walker, MD

Other units associated with the laboratories are the Transplant Surgical Research Laboratory, headed by G. Melville Williams, MD; the Allergy and Hypersensitivity Disease Section, headed by Philip S. Norman, MD; and the Respiratory Laboratory, headed by Peter C. Luchsinger, MD.

The laboratories occupy the north wing of The Good Samaritan Hospital and were built with funds from the estate of Thomas O'Neill, a Baltimore merchant who died in 1919. Funds from his estate also built Good Samaritan and the Roman Catholic Cathedral of Mary Our Queen in Baltimore.

●

Two big ideas I learned about smoking are the nicotine obeys whatever command the smoker gives, and that a person should find a clue to his psychological reason for smoking.

Peter Steele Bixby
SMOKE SIGNALS,
November 1969



PRESIDENTIAL BANQUET—Business and pleasure combined to make the evening of May 4 a memorable one for the record-breaking crowd attending the 174th Annual Med-Chi Meeting. The President's reception and banquet were followed by presentations and dancing. Seated at the head table, from the left, were: Robert B. Hunter, MD, member, Board of Trustees, AMA; Robert A. Reiter, MD; Mrs. John B. DeHoff; Martin L. Singewald, MD; Mrs. Howard Liljestrand of Hawaii, a director, AMA Woman's Auxiliary; Rev. Carroll Gunkel; Mrs. John F. Schaefer; Dr. Schaefer, Faculty president, standing; Mrs. Robert A. Reiter, president, Woman's Auxiliary; John B. De Hoff, chairman, Committee on Program and Arrangements; Mrs. Carroll Gunkel; Henry A. Briele, MD, immediate past president; Mrs. Martin L. Singewald; Frederick Merchant, MD, general chairman of FLEX; and Karl F. Mech, MD, president of the Board of Medical Examiners of Maryland and Faculty treasurer.

## Resuscitation for Coronary Victims

The American College of Physicians has recommended that a massive education program be conducted to teach the general public how to resuscitate victims of coronary heart attacks.

A statement issued following the 53rd Annual Meeting of the 20,000-member medical specialty society (held in Atlantic City April 17-21, 1972) said:

"It is estimated that more than half of those who die from an initial coronary heart attack do so before they reach a hospital. It is also well recognized that from the time of onset of a "cardiac arrest" no more than three or four minutes may be allowed to elapse before starting resuscitation."

To bring immediate help to victims of coronary heart attacks and to reduce the number of unnecessary sudden deaths, the ACP recommended that hospitals throughout the country gear for the training of emergency procedure to "all citizens, and to groups such as Boy Scouts, Girl Scouts, lifeguards, public utility employees, policemen, firemen, ambulance personnel, and members of the armed forces."

The emergency procedure would include recognition of the cardiac emergency, as well as its treatment by such methods as pounding on the chest, mouth-to-mouth respiration and closed cardiac massage.

## Hospital Charity Work

"Regulations proposed by the secretary of HEW requiring that hospitals increase their charity work in order to qualify for and retain Hill-Burton funding is seeking to relieve a governmental responsibility by further burdening the private institution," according to Madison B. Brown, MD, acting executive president of the American Hospital Association.

"The failure of government at the national, state, and local levels to pay in full for services provided to beneficiaries of these governmental programs adds severely to the financial crisis faced by health care institutions," Dr. Brown continued.

On April 18, Secretary Richardson proposed that all health care facilities that have received Hill-Burton grants, loans, or loan guarantees, provide free services to the poor at a level of not less than 5% of their total operating costs or not less than 25% of their net incomes, whichever is greater.

Dr. Brown emphasized that AHA has and will continue to support the broad objective of high-quality health care for all people, and that this support is currently being demonstrated through services for the poor and near poor in hospitals.

He further stated that the Association is gravely concerned by the implications for hospitals of these recommendations.

A copy of their detailed statement of specific objections to these recommendations may be secured by writing the AHA, 840 N Lake Shore Dr, Chicago Ill 80611.

## Regional Cancer Center Planned

The first step toward the development of a regional cancer center caring for more than 2,000 patients a year was taken recently when Maryland Governor Marvin Mandel signed Senate Bill 266 into law.

The bill provides $2 million in state matching funds as part of an $8 million package needed to develop the center at Baltimore City Hospitals.

The Johns Hopkins University School of Medicine, which will operate the center jointly with BCH, has applied to the National Cancer Institute for the $6 million still needed.

Albert H. Owens, Jr., MD, professor of medicine at Hopkins and director of the joint oncology program, said the center at BCH will provide specialized programs in cancer surgery, radiation therapy and drug therapy, and will be able to apply research findings to patient care immediately.

The cancer center, Dr. Owens added, will have 100 beds for inpatients and sophisticated treatment facilities for ambulatory patients. In addition, he said, there will be a special unit for children and an advanced radiation therapy unit.

About 35,00 sq ft of laboratory space, he said, will be available for research concerned with cancer's cure and prevention.

In addition, teaching programs will be conducted for medical students of Hopkins and the University of Maryland, interns and residents of Hopkins and Baltimore City Hospitals, practicing physicians, and other health professionals, he said.

The need for such a center is great, Dr. Owens pointed out, since cancer will develop in 12,000 or more Marylanders each year.

"Though one out of three cancer victims can be cured by modern therapy and long-lasting comfort provided to countless others," he said, "cancer still remains a major health problem and new knowledge gained through research is needed to improve the outlook."

Dr. Owens added that the center will complement the laboratory-based cancer research programs at Fort Detrick and the National Cancer Institute in Bethesda.

"Effective collaboration," he said, "can provide Maryland a combined cancer conquest ability equaled in few other areas."

City Hospitals has pledged its "C" building, formerly used for tuberculosis patients, for use of the center, according to Frederic G. Hubbard, Baltimore City Hospitals director.

The $8 million needed for initial financing will be used for extensive renovation in the "C" building and for new construction, Mr. Hubbard said. An additional $2 million is being sought from other sources to obtain radiation therapy units and special equipment not available through federal grants.

Dr. Owens said the cancer center will require about $10 million a year in operating funds, including $6 million for patient services and $4 million for research and teaching.

Third-party sources, such as health insurance companies, will provide about 80% of the patient service costs, while grants will cover the remainder as well as the research and teaching costs, he said.

A 20-bed cancer unit with research facilities, which opened at City Hospitals in 1962 under joint Johns Hopkins - BCH - NCI sponsorship, doubled its research space.

## Alcoholism Program

Two new facilities for alcoholics — Alpha House for women and Nillson House for men — were officially opened in downtown Baltimore recently as part of the alcoholism program of the University of Maryland School of Medicine.

Alpha House is the first facility of its kind in the country, according to Wendy Maters, nurse coordinator of alcoholic services at University Hospital. Funded through Baltimore's Model Cities program, Alpha House is a quarter-way house for female alcoholics who have been referred from Provident or University hospitals. It and the women's half-way house associated with it are operated by the Alpha House Foundation.

Women who come here receive a 14-day program of counseling, rehabilitation, medical supervision, and referral services.

Nillson House, a half-way house for male alcoholics, is a follow-up facility for nearby Tuerk House, a men's quarter-way house which was opened two years ago as the first residential facility in University's alcoholism program.

Both Tuerk and Nillson houses are operated by Quarter-Way Houses, Inc., and funded by the State Department of Mental Hygiene.

Residents, who are employed and in the process of rehabilitation, stay for up to six months and pay their own room and board. At Nillson House the men receive needed supporting communal environment and professional counseling.

## Sheppard Pratt Report Emphasizes Community Service

"The Sheppard and Enoch Pratt Hospital, Towson, is cognizant of the challenge of reorganizing mental health care by utilizing the opportunities society has provided by its growing concern and support for improving mental services. In addition, we are trying to avoid the pitfalls of comprising essential elements of good health care."

These objectives were outlined by Robert W. Gibson, MD, Sheppard Pratt's medical director, in the hospital's 1970-71 Annual Report, now in current distribution.

"In the hospital's immediate area of Towson-Northern Baltimore County, we are striving to meet its overall needs by developing a comprehensive community mental health center," Dr. Gibson stated.

He added, "For Baltimore County, we are actively assisting various agencies and organizations charged with meeting the total mental health needs of the county, including evaluating and consulting youthful offenders at the Baltimore County Courts, conducting seminars for Baltimore City and Baltimore County police recruits, and providing crisis-oriented therapeutic measures to hospitalized children."

He continued, "We are participating on a limited basis in selected mental health programs and on several advisory planning committees, including a prepaid group program largely funded by the Maryland Medicaid Program, to meet the needs of both welfare recipients and the medically indigent."

Sheppard Pratt child psychiatry resident fellows work with preschool, emotionally disturbed children at the Children's Guild. In cooperation with Greater Baltimore Medical Center, the staff provides for an inner city ghetto comprehensive pediatric care clinic.

At the state level, efforts are primarily directed toward education, research, and advisory activities.

"In the Middle Atlantic, national, and international areas, our contributions come mainly through offering intensive psychiatric care to patients, education of adults and children psychiatrists, research, and participating in organizations that work to promote mental health," Dr. Gibson concluded.

## Use of Mobile X-Ray Equipment Questioned

The use of mobile equipment for X-raying members of the general public for tuberculosis and other chest diseases should stop, says a new mass X-ray policy statement prepared jointly by the HEW Food and Drug Administration, the American College of Chest Physicians, and the American College of Radiology.

The kind of equipment found in highway vans in many parts of the country is not productive as a screening procedure for chest disease detection, the statement says.

Merlin K. Du Val, MD, of HEW, said the new policy was dictated in large part by the fact that tuberculosis is now almost nonexistent in many parts of the country. "The use of mobile equipment, which requires relatively higher levels of X-ray exposure than fixed equipment, simply cannot be justified," Dr. Du Val said.

Copies of the complete statement may be secured by writing to Information Office, Bureau of Radiological Health, 5600 Fishers Lane, Rockville Md 20852.


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# Dr. Singewald Receives Community Service Award

One of the highlights of the Presidential Banquet at the 174th Annual Meeting was the presentation of this year's Community Service Award to Martin L. Singewald, MD, of Baltimore.

Minus the quotation marks, here is what the Faculty president, John F. Schaefer, MD, had to say about Dr. Singewald before being photographed with him and the plaque:

Dr. Martin L. Singewald is one of the most outstanding members of the Baltimore medical community. He represents the finest in American medicine today. His high standards and his dedication; his ability to be conversant with the very latest medical care and medical research, and at the same time to devote such a high percentage of his time to community and religious activities reveals a man of unusual qualifications. His quiet demeanor, his selflessness, belie the intensity of the good works he does, quietly, effectively, and with anonymity.

Dr. Singewald graduated from The Johns Hopkins University with a Bachelor of Engineering degree, and for two years did research work in electrical engineering in the Bell Telephone Laboratories, but he soon found that his talents and his call was in medicine. He enrolled in The Johns Hopkins University School of Medicine where he received his MD in 1938. He was an intern at the Baltimore City Hospitals, and for a second year at the Mary Imogene Bassett Hospital in Cooperstown, NY. He returned to The Johns Hopkins Hospital where he was an assistant resident and resident in medicine. Upon completion of his residency he went with the 18th General Hospital and served in the US Army Medical Corps and was discharged with distinction with the rank of Lt Col.

He has been in the private practice of medicine since his return from Army service. He has been a physician on the active staff of The Johns Hopkins Hospital, The Church Home and Hospital, The Greater Baltimore Medical Center, The Union Memorial Hospital, and The Good Samaritan Hospital. His medical activities have been great and generous. He is a Diplomate in the American Board of Internal Medicine, a Fellow of the American College of Physicians, and has served as Governor for Maryland from 1966 to the present time. He is an associate professor of medicine in The Johns Hopkins University School of Medicine. He served as president of the Maryland Hospital Service from 1959 through 1960. He has been a consultant to the Surgeon General of the Army since 1960.



AWARD WINNER—Martin L. Singewald, MD, left, accepts the Community Service Award from John F. Schaefer, MD, Faculty president. Presentation was made during the Presidential Banquet on May 4.

He has served the Baltimore Presbytery in many ways. He is an Elder of the Hunting Ridge Presbyterian Church, and chairman of its Evangelism Committee. He is a member of the Board of Directors of the Maryland Chapter of Presbyterian Laymen, and a member of many of its committees. He serves the Episcopal Diocese of Maryland on its College Work Committee, and is a member of the Campus Ministry Committee of the University of Maryland. He has been active in the Campus Ministry in the promotion of various denominational work for over ten years serving the Baptist, Lutheran, Presbyterian, Episcopal, and Catholic denominations in both the University of Maryland and The Johns Hopkins University. He has been a personal member of the National Council of Churches, and the Christian Medical Association.

For the past six years he has worked regularly as a physician-volunteer at the Baltimore Rescue Mission and the Helping-Up Mission. He was a member of the Citizens Advisory Committee for the Baltimore Public Schools from 1962 through 1964, and has been a Maryland member of the National Committee for the Support of Public Schools through last year. He has served actively in the Parent-Teacher Association at a local, state, and national level. He was chairman of a city-wide committee to relocate Western High School.

He has performed many fund-raising activities quietly and effectively. He has served as chairman of the Johns Hopkins University Roll Call. He is a member of the Centennial Commission of The Johns Hopkins University, a member of the

Board of Directors of the Johns Hopkins Club, and a member of the Editorial Board of the Johns Hopkins Medical Journal. He is now president of the Johns Hopkins Alumni Association. He served as a member of the Committee on Religion and Medicine for the Baltimore City Medical Society for ten years, and has been its chairman for the past two years.

The pleasure and joy obviously derived from such medical and community activities are reflected by the happiness he brings into all of his relationships. He has been an inspiration to his medical colleagues, to the house physicians and medical students who have profited so much from his teaching, to his patients, and to his many friends and members of the community-at-large. There is no one in the community to whom so many would rather pay homage and tribute than to Dr. Martin L. Singewald who is the recipient of Med-Chi's Community Service Award for 1972.

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**the heart page**

# ANTIMICROBIC PROPHYLAXIS AGAINST INFECTIVE ENDOCARDITIS

**MICHAEL L. LEVIN, MD**
**Head, Division of Infectious Diseases**
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**Baltimore**

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Antimicrobic prophylaxis preceding operative or manipulative procedures has been advocated for patients with abnormal cardiac valves* to reduce the risk of bacterial endocarditis. The use of antimicrobics in this manner is aimed at the transitory bacteremia which may develop during manipulation of a focus harboring potentially pathogenic bacteria. This umbrella of chemotherapy is not effective in preventing the bacteremia, but rather serves to decrease its duration and magnitude.

Foci from which bacteremias and endocarditis originate frequently are within the oropharynx, perineal tissues, or skin. The responsible bacteria are part of the normal flora of these mucocutaneous areas. When these anatomic sites harbor an overt infection (eg, periapical tooth abscess; gingivitis; an inflammatory process of the skin, reproductive glands, or perirectal tissues), the focus of bacteremia and endocarditis is apparent [1] During a seemingly innocuous procedure, in the absence of an overt infection, these mucocutaneous areas may nonetheless serve as the focus for as pernicious a disease as endocarditis. There are many procedures for which the clinician often does not consider the need for prophylaxis, but for which such therapy is necessary (eg, periodontal procedures, tonsillectomy, dilatation of the cervix and curettage of the uterus, parturition, placement of an intrauterine device, prostatic massage, endoscopy of the genitourinary or colonic tissues). Therefore, in the absence of overt infection, when manipulation of these anatomic sites is anticipated, all patients with abnormal cardiac valves should receive antimicrobic prophylaxis.

There is no general agreement concerning the duration or the mode of administration for optimal antimicrobic prophylaxis.[2-5] Most clinicians do agree that the aim of such therapy is to achieve peak serum levels of the antimicrobic prior to manipulation and to maintain this therapy into the postmanipulative period for 24 to 36 hours. Clinical studies have documented that the most prevalent period for transient bacteremia to occur is within five minutes of maximal trauma.[6] Since bacteremias may not be prevented by prophylactic antimicrobics, therapy should be extended into the postmanipulative period to eradicate those few organisms which may have lodged on cardiac valves. Once a nidus of infection establishes itself on the avascular valve, its eradication becomes more difficult.

The choice of antimicrobic agent(s) to provide the most effective chemoprophylaxis may be a perplexing one. This choice is based upon knowledge of the normal flora of the involved anatomic sites. As there is variation of "normal flora" from one anatomic site to another, so there is variation in optimal antimicrobic

* *The term "abnormal cardiac valves" is meant to include any deformity irrespective of its etiology (eg, rheumatic, congenital, luetic, arteriosclerotic—as well as prosthetic endocardial devices).*

therapy. Unfortunately at present, there is no single agent to provide adequate prophylaxis simultaneously against flora of skin, oropharnyx, and pelvic tissues. Ideal therapy should be the least toxic, most inexpensive bacteriocidal agent directed against that segment of normal flora (residing in the anatomic site in question), which if discharged into the circulation usually is responsible for infective endocarditis.

In the preantibiotic era, the agent most frequently responsible for subacute bacterial endocarditis was alpha hemolytic Streptococcus (collectively referred to as "viridans" group). The principal significance of the viridans group of Streptococci relates specifically to subacute endocarditis. With advances in antimicrobic therapy, cardiovascular surgery, and immunosuppressive therapy, the host has been altered and the varieties of organisms responsible for endocarditis have become more numerous. Recently, gram-negative bacilli, fungi and Staphylococci (S. aureus and S. albus) have played a more prominent role as the etiologic agents of endocarditis. The previously labeled "nonpathogenic" S. albus has proved its pathogenicity in the altered host; not infrequently as subacute endocarditis on a prosthetic valve.[7-11]

Despite these changes, Streptococcus remains responsible for more than 75%[7-11] of the cases of subacute bacterial endocarditis. Of the subdivisions of Streptococcus, the viridans group (including the facultative anaerobes, obligate anaerobes, and the microaerophalic Streptococci) accounts for more than 50%[7-11] of the streptococcal subacute bacterial endocardites. The anatomic site from which S. viridans is recovered most frequently is the dento-gingival sulcus (or pocket). This accounts for the frequently reported relationship between dental procedures and subsequent S. viridans endocarditis.[12]

Until recently, S. viridans had been reported to be exquisitely sensitive to small concentrations of penicillin (less than 0.1 u/cc). However, a relative increase in penicillin resistance in persons receiving long-term oral penicillin prophylaxis for the prevention of recurrent rheumatic fever has been reported.[13-15] If such patients receive monthly benzathane penicillin rather than a daily oral form, they demonstrate a statistically significant lower incidence of carrying resistant S. viridans in their oropharynges.[16] On occasion, those S. viridans resistant to penicillin may also be resistant to other antibiotics.[17] However, patients receiving antimicrobics other than penicillin (eg, sulfonamides, erythromycins, lincomycins, tetracyclines, or cephalosporins) as prophylaxis against recurrent rheumatic fever, do not carry significant numbers of penicillin-resistant Streptococci. As anticipated, endocarditis occurring in patients harboring resistant oral S. viridans is caused by similarly resistant S. viridans. Theoretically, there is a need for a higher concentration of penicillin to eradicate such infections.

The failure to appreciate this variation in streptococcal sensitivities to penicillin may result in suboptimal therapy and consequently a failure to eradicate the endocarditis. Therefore, in my opinion, patients with valvular deformities who are about to undergo manipulative procedures of the oropharynx, and who have received long term oral penicillin therapy, should receive prophylactic therapy with drugs other than penicillin. Alternative approaches would be to increase significantly the oral dose of penicillin over that previously being administered or administer parenteral penicillin. This higher concentration of penicillin hopefully would be serumcidal for the resistant S. viridans.

Though S. viridans is the organism most frequently responsible for endocarditis, S. fecalis (enterococci) also plays an important role. Enterococcus, unlike S. viridans, is not cultured as commonly from the oropharynx. It is part of the normal genitourinary and colonic flora. S. fecalis also differs from S. viridans in that S. fecalis has a wide variation in its spectrum of penicillin sensitivity. A few strains can be eradicated by less than 0.1 u/cc penicillin; others are killed only with higher concentrations of penicillin; and a significant number require the synergistic action of an aminoglycoside with penicillin. Ampicillin (usually not the cephalosporins, tetracyclines, sulfonamides, lincomycin, or erythromycins) does provide effective therapy for certain strains of S. fecalis. Because of this variation in sensitivity, penicillin *per se* must be considered a suboptimal choice of therapy as chemoprophylaxis during manipulative procedures involving the genitourinary or colonic areas.

Hemolytic Staphylococcus aureus is reported to be the most prevalent *acute* form of endocarditis today. This organism is part of the normal skin flora and on occasion is carried chronically in the anterior nares. In those patients with overt cutaneous infections (furuncles, carbuncles, cellulitis secondary to "main-line" drug use), who develop bacteremias and endocardites, Staphylococcus is the organism most frequently recovered.

In recent years, the number of penicillinase-producing Staphylococci has increased significantly in both nosocomial and community-acquired infections. Unless laboratory studies con-

firm the strain of Staphylococcus in question to be penicillin-sensitive, the clinician may assume it to be a penicillinase-producer and thus totally resistant to penicillin. If these localized areas of infection are to be incised and drained, a peak blood concentration of a semisynthetic penicillin (dicloxacillin or cloxacillin) is considered optimal prophylaxis against the potential Staphylococcal bacteremia. If laboratory reports do confirm the Staphylococcus to be a penicillin-sensitive (ie, a non-penicillinase producer) strain, then penicillin *per se* is the prophylactic agent of choice.

In summary, a guide for antimicrobic prophylaxis for patients with abnormal cardiac valves who are about to undergo manipulative procedures should include:

1) For those patients with abnormal cardiac valves who are about to undergo oropharyngeal procedures, prescribe oral penicillin. Prophylactic therapy is aimed at maintenance of adequate serum levels from four hours prior to 36 hours after the procedure. If these patients are already receiving rheumatic fever prophylaxis with daily oral penicillin, their prophylaxis (for the same time duration) should include either an oral erythromycin; cephalosporin*; sulfonamide, or clindamycin. An alternative therapy is parenteral procaine penicillin 600,000u. b.i.d. or a significantly higher dose of oral penicillin.

2) For those patients about to undergo genitourinary manipulation, prescribe either an oral ampicillin or a tetracycline, in conjunction with intramuscular kanamycin or streptomycin every 12 hours. Prophylactic therapy is aimed at maintenance of adequate serum levels from four hours prior to 36 hours after the procedure.

3) For those patients who are about to have infected skin lesions excised, an oral semisynthetic penicillin (eg, dicloxacillin or cloxacillin**) is considered optimal prophylaxis. (Penicillin is preferred *if* the Staphylococcus in question does not produce penicillinase.)

4) For the patient about to undergo cardiac valve replacement, intravenous therapy with a semisynthetic penicillin effective against penicillinase-producing Staphylococcus (eg, methacillin, nafcillin, oxacillin) is preferred as prophylaxis. Prophylactic therapy is aimed at maintenance of adequate serum levels from 24 hours prior to 96 hours postoperatively.

5) For those patients in whom penicillin is contraindicated, the oral form of an erythromycin, a cephalosporin, a sulfonamide or clindamycin is effective as prophylaxis against streptococcal viridans. An oral cephalosporin or clindamycin provides effective prophylaxis against most penicillinase-producing Staphylococci.

* *There is a degree of cross-allergenicity between the penicillins and cephalosporins.*

** *Oral oxacillin does not achieve as reliable serum levels as the chlorinated forms of semisynthetic penicillin.*

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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# Medical Education in Maryland in the Eighteenth Century

DOUGLAS CARROLL, MD
Baltimore City Hospitals
Baltimore

*This is the fifth of a ten-part series of articles on the history of medicine in Maryland from 1634 to 1835 written by Dr. Carroll.*

***"The general intellectual climate of the later eighteenth century was in marked contrast to that of the earlier decades. From the point of view of scientific men, it became distinctly fair and warmer. Modern experimental science, having developed rapidly during the seventeenth century, came into its own in the eighteenth . . . British empirical philosophers and British mathematicians were influential in establishing throughout Western Europe the new 'scientific point of view.' In its essence, this was the conviction that the ultimate truths of Nature transcended human understanding, but that man could learn through experience to control Nature to his own ends."***

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The opportunities for education in the colony were few. It is not surprising, therefore, that a good education was highly prized and insured a financially successful life. Much of the elementary education was carried on in the family. Schools were occasionally organized by members of the clergy. Perhaps the most famous in Maryland was the one founded by Reverend Thomas Cradock, rector of St. Thomas' Parish in Baltimore County. He founded the school in 1747 in his own house and continued teaching until his death in 1770. A school run by Jesuits was organized at Bohemia Manor (attended by Charles Carroll of Carrollton and Bishop John Carroll). Jonathan Boucher, rector of St. Ann's Church, Annapolis, had a school in 1771 and 1772.

The richer families occasionally sent their sons to grammar school in Europe. Charles Carroll of Carrollton and Bishop John Carroll received higher education at the Jesuit school at St. Omer, France. Benjamin Ogle (1746-1809) received his early education in England. William Smallwood (1732-1792) graduated from Eton. Charles Carroll, Barrister (1723-1783), received his elementary education is Lisbon, Portugal. His father had planned for him to go to England, but when an unexpected wind brought the ship to Portugal, a satisfactory English school was found in Lisbon. Later he attended Clare College, Cambridge, before studying law at the Middle Temple, London.

In 1752 a Mr. James Gardner kept a school near South and Water Sts in Baltimore, but it must have been inadequate, for in the Maryland Gazette of Feb 27, 1752, there is an advertisement for a schoolmaster "of a good sober character, who understands teaching English, writing and arithmetic" who "will meet with very good encouragement from the inhabitants of Baltimore town, if well recommended." We do not know whether this ad was answered.

A few rich families employed a tutor: William Pinckney (1764-1822) and Thomas Stone (1743-1787) had private tutors. Samuel Chase's father, who was both a physician and priest, tutored him assiduously.

Higher education was difficult to obtain. A few Maryland youths were educated at the College of New Jersey (now Princeton University): Thomas John Claggett (1741-1816), Class of 1764, and John Henry (1750-1798), Class of 1769; William and Mary College: George Plater (1735-1792), Class of 1753, and John Francis Mercer (1749-1821), Class of 1775); and the College of Philadelphia (now University of Pennsylvania): Charles Goldsborough, Class of 1784, and William Paca (1740-1799), Class of 1759. Washington College in Chestertown: Robert Wright (1752-1826); and King William's School (now St. John's College): William Pinckney (1764-1822), which was founded in 1696, were also used, being closer at hand.

There were several lines which a well-educated man might pursue. That of the law was the most popular and might be entered by spending several years of training at the Inns of Court in London or as an apprentice to someone who had studied at the Inns. Many early governors of Maryland were drawn from this group of lawyers. In addition to a political career, a law education was of tremendous help in the commercial life of the colony—whether it was shipping, iron production, or tobacco planting.

Medicine was a less popular profession. Several are known to have studied in Edinburgh: William Quynn (1760-1784); London: Andrew Wiesenthal (1762-1798); or later at the new Philadelphia College: Philip Thomas (1747-1815), Samuel Stringer Coale (1754-1798), Thomas Drysdale (1770-1798), and Richard Hopkins (1762-1830); but most of the Maryland colonial physicians had been born and trained in Europe (Alexander Hamilton and George Buchanan). Another interesting trend was for those trained in medicine in Europe to take to other pursuits when they arrived in the colonies, and not a few medical men made names or fortunes in other fields (James McHenry, Henry Dearborn, James Wilkinson, Dr. Charles Carroll and Thomas Chase). Actually few of the prominent doctors in the colonies made their reputations on their clinical ability alone; more often it was as a teacher, patriot, or administrator (John Morgan, Benjamin Rush, William Shippen).

The clergy had still fewer native aspirants (Bishop John Carroll and Bishop Thomas John Claggett). They were chronically underpaid, despite the 40-pound tobacco tax (to Anglican clergy only), and many took to teaching on the side as a way of supplementing their income (Thomas Cradock, Jonathan Boucher). A few were both physicians and priests (Thomas Chase).

European culture was brought to the colonies through men and the written word. Dr. Alexander Hamilton represents Renaissance man: scholar, gentleman, poet, social observer, undertaking the bold feat of settling in the New World and with endurance and courage building a new and successful life.

As the colonies developed, some of the native-born youth became apprentices to the older doctors such as Charles Frederick Wiesenthal. George Buchanan, Andrew Wiesenthal, and Richard Brooke represent a second stage of transfer of culture from the Old World: an apprenticeship with a physician in the colonies followed by further training in Europe.

Early American students had preferred Leyden and Paris as centers of medical education; after 1760, Edinburgh became the favorite. In 1765, five Americans received their medical degrees from Edinburgh.[1] Between 1758 and 1788, 63 colonists studied medicine at Edinburgh.[2] By 1802, Samuel L. Mitchell pointed out proudly that there were no Ediuburgh graduates from the United States in that year.[3] Edinburgh could blame itself largely for this change, for it was from the halls of the University of Edinburgh that William Shippen, Jr., and John Morgan went back to Philadelphia to pioneer the first colonial medical school.

Thus the transfer of medical education from Europe to the colonies was completed when John Archer (1741-1810) of Maryland became the first graduate of an American medical school in 1768.

Letters from two medical students in 1782 to 1785 are available.[4,5]

William Quynn (1760-1784), born and raised in Annapolis, was the son of Allen Quynn, a patriot active in the Revolutionary War. William studied as an apprentice under James Murray (1739-1819), and probably Dr. James Stewart (1755-1845). Both of these physicians had studied in Edinburgh. Stewart was a graduate, but Murray probably graduated at Glasgow. Quynn was commissioned surgeon on the privateer brig *Cato* on Nov 20, 1780, and was presumably a capable physician at that time. His naval career was cut short by a sea engagement in which the *Cato* was blown up. After the war he went to Philadelphia to study at the University of Pennsylvania Medical School. His letters give some details of his studies. Dr. Shippen's lectures on physiology, anatomy, and surgery were expensive, but "I expect to acquire great improvements; we have prevailed on Dr. Shippen to attend the dissecting Class." The medical students were dissecting an animal and the practice "gives him fortitude and resolution to exercise his knife upon a living Animal."

The days were spent with the professors, and the nights in quiz sessions also conducted by the professors on the day's lectures. "It is unfortunate for the Students that the dessention which subsists between Dr. Rush and Dr. Shippen prevents Rush's Lecturing on Chymistry, a branch, Indispensably necessary to constitute a Physician."

In August 1783, Quynn sailed to London to continue his studies. He remained in London until October 1783 when he went to Edinburgh, "the great Luminary of the medical department—." He planned to spend 18 months in

Edinburgh. Because he found it impossible to fulfill the three-year requirement for a degree from Edinburgh, he planned to "graduate as a Physician" at St. Andrews or Glasgow. Then back to London to walk the hospitals there.

In Edinburgh he found about 500 students attending the lectures of Alexander Monro, secundus (1733-1817). William Cullen (1710-1790) lectured in the Episcopal Chapel. While in Edinburgh, he joined the Royal Medical Society "where all Medical matters are discussed."

"There is a great spirit of Controversy among our Professors new Theories appear daily, but I believe they commence Authors more for a display of ingenuity—than from any real benefits that Society can possibly derive from it. I am happy to inform you, that the same professors who lectured here, during Dr. Murrays residence in this City, still continue to lecture—By which I find an utter revolution to have taken place in the Practice—by their endeavoring to obliterate the Doctrines they formerly advanced, and which I find Dr. Murray seems to have imbibed—.

"My Dear Father; you seem to be over anxious for my attaining a proficiency in my Profession— . . . I begin to be much of Dr. Murray's Opinion with respect to practice here and in the London Hospitals—for I find the Physicians here much more attentive to the deseased Poor than they are in London—."

Writing in May of 1784 he notes, "Our Anatomical classes are now terminated, and the summer Classes in the Different branches of medicine and Pharmacy will Commence next week—I mean to attend three of them viz—On Mid-Wifery-Botany and Materia Medica." His plans were tragically ended with his sudden and unexpected death.

Quynn's education was typical of the time. First an apprenticeship, followed by service as a physician in the Revolutionary War. Then lectures at Philadelphia, Edinburgh, and walking the London hospitals. His plan for a short visit to the Paris hospitals was never fulfilled.

Richard Hopkins' (1762-1830+) experience in Philadelphia[5] was almost contemporaneous with Quynn's. Hopkins remained there from about June 1782 to the spring of 1785. He appears to have been a student at the medical school, but also worked in the office of Dr. Adam Kuhn.

In January of 1784, he writes his mother of "my too close application to a multiplicity of reading by my having access to a library of twenty thousand volumes which has so far weakened my health and constitution, and such constant pouring over Books in a bended posture that has brought on a pain in the Breast which has produced a spitting of blood which seems to threaten a consumptive tendency, which is somewhat alarming considering my Dear Father was consumptive, therefore there is the greatest necessity for the restoration of my health that I relax somewhat from hard study, and that I enjoy country air."

He mentions that he has to undergo a "severe examination before the Trustees of the Colledge previous to my publick exhibition for the getting a Diploma in the Colledge which requires a severe scrutiny of the qualifications of a candidate." On his return to Maryland, Hopkins had a profuse hemorrhage following a welcoming home banquet by his friends. For several months he had fever and sputum with great weight loss. He wrote a classmate, Henry Stuber, for encouragement. Stuber's answer brought Hopkins glad greetings from his old friend Professor Kuhn: "Your old Master Professor Kuhn seeams rejoyced to hear you are in a fair way to recover, but says he, I am much mistaken if he is not actually consumptive and much I fear his recovery will be only temporary, and shou'd he attempt the Practice of Physick in the Country as there is so much riding in the Night in Country Practice, the first deep cold that he gets much I apprehend that his consumptive complaint will return upon him, and he has desired me to warn you accordingly." Cordell[6] says of Hopkins, "Died about 1830-35, at a great age." A subsequent letter from Philadelphia announced that "our mutual friend Stuber has closed his eyes upon this scene of things in the sublimary world."

## Early Apprentice Medical Schools in Maryland

There are three charming examples of medical schools run by single practitioners in their homes. Each of these physicians was a leading practitioner in his community. Each had a son who became a doctor, and in several cases the apprentice physicians married their preceptor's daughters.

The earliest family school was that of Dr. Gustavus Brown (1689-1762), who was born in Dalkeith, Scotland. His grandfather was a graduate of the University of St. Andrews and a priest in the Established Church of England.[7]

We know nothing of Dr. Gustavus Brown's education,[8] but he came to Maryland in 1708 as a surgeon or mate on a British ship. During a period of inactivity, while his ship was at anchor

in the Chesapeake Bay, he came ashore on an exploring trip. A storm arose, and he was stranded when the ship had to put out to sea. He thereupon made himself known to the local planters, settled at Nansemond, Md and began a successful practice of medicine. In 1710 he married Frances Fowke, the daughter of a local planter, and later bought a plantation, "Rich Hill," four miles from Port Tobacco, Charles County. Of the 12 children by this marriage, one son and seven daughters survived. His first wife having died in 1744, Dr. Brown married for a second time and had two children, a son and daughter. The son by the second marriage was Gustavus Richard Brown (1747-1804).

Brown returned to Scotland with his first wife, but she became dissatisfied and they returned to Maryland in 1734. In the same year he started training his first apprentice. Most physician apprentices were local boys who wanted to practice medicine, but Michael Wallace (1719-1767), Brown's first apprentice, came as an indentured servant bound "to be an Apprentice and Servant to the said Doctor Gustavus Brown in his Business and Imployment of Physick Surgery and Pharmacy During the space of Six Years." Wallace's arrival (1734) coincided closely with Brown's return from Scotland, so that it is likely that the families knew each other in Scotland and arrangements for his training had been made before leaving Scotland. In any case, Wallace was fully accepted as one of Brown's family and later married one of Brown's nine daughters.

The indenture of Dr. Michael Wallace[7] stipulates that "he shall forbear all Gameing Drinking and Keeping of Idle Company and shall not Dureing his said Apprenticeship have any patients of his own under Cure Upon No Pretence whatsoever." Brown in turn "shall not only Teach Learn and Instruct the said Michaell Wallace his Apprentice In the Art of Physic Surgery and Pharmacy forsaid in every part and point thereof and to use his best and utmost Endeavour to make him Expert and Perfect therein so far as he knows himself or the Judgement and Capacity of the said Michaell Wallace is Able to Uptake But also to pay for his passage to the said County in Maryland And there to furnish provide and entertain him During the space of ther Intendures in Meat Drink Cloathing Lodgeing and Washing and All Other Necessaries as becomes an Apprentice."

Dr Brown was active in local church, school, and government matters. He was an Associate Judge of Charles County Court in 1755. A number of medical students studied at "Rich Hill." Michael Wallace and John Key married two of his daughters. All the nine daughters married, four to ministers, one to Thomas Stone, a signer of the Declaration of Independence.

Dr. Brown died at "Rich Hill" of apoplexy in 1762. His son by his second marriage, Gustavus Richard Brown, was educated at University of Edinburgh (MD 1768). One of his classmates was Benjamin Rush of Philadelphia. Young Brown then walked the London Hospitals for several months. He was particularly interested in plants and flowers and brought back with him a large collection from the Madeira Islands where he spent several months. He settled in Port Tobacco, was appointed to the County Committee of Correspondence after the closure of the Port of Boston in 1774, and, like his father, became a County Judge in 1776. In 1776, with his nephew James Wallace, who was also one of his pupils, he set up a smallpox innoculation hospital in Charles County. A personal friend of George Washington, he was called into consultation in Washington's last illness.

Following the Revolution, he had a number of apprentices at his home in Port Tobacco. A brick house connected to his residence by a covered walk served as his medical school where he had as many as ten apprentices at a time. A large basement served as a dissecting room, and under this was a subcellar, traditionally said to be a morgue for storage of bodies for dissection.

* * * * *

A second illustration of a family medical school is that of Charles Frederick Wiesenthal (1726-1789) and his son Andrew (1762-1798). Charles arrived in Baltimore in about 1755.[8] He is believed to have had experience in the Prussion Army, but his medical education is unknown. He married a lady from York, Pa, had one son, Andrew, and three daughters. He held a number of important positions during the Revolutionary War, being on the Committee of Observation of Baltimore County, Superintendent of the Manufacture of Saltpetre for the state, Medical Purveyor for Maryland troops, examiner of physicians entering the Armed Forces, Surgeon-General of Maryland troops. He does not appear to have served in the field during the Revolutionary War. He was a strong supporter of the first Lutheran Church built in Baltimore.[9]

Several years after settling in Baltimore, he moved into a house on Gay and Fayette Sts. He used an adjoining house for his office. Several substantial brick buildings in the rear were erected for his medical school and dissecting

room. The main building was a two-story building 72 x 20 ft. A letter in 1787 mentions that a negro boy was being dissected at the time by his nephew and student Frederick Dalcho (1770-1836). It seems probable that Wiesenthal was the first man in Baltimore to perform anatomical dissections, as well as perform autopsies (cases 1 and 2).[10]

Dissections and autopsies prior to the 1730s were often performed for legal purposes[11] and had no organized medical teaching or research purpose.[12] Thomas Cadwalader of Philadelphia gave the first formal lectures in anatomy with demonstraters in this decade. Thomas Bond in 1766 delivered an important lecture on the value of morbid anatomy, but animals rather than humans were used for dissection in the medical school of Philadelphia at the time of William Quynn in 1782.[4]

The clear demonstration of the importance of organs and local causes of disease came in 1761 with the work of Morgagni. His clinical-pathological correlations clearly demonstrated the importance of the autopsy in clinical medicine.[13]

There was popular aversion to both human anatomical dissection and post-mortem examination. By 1800 these procedures, long carried out in Europe, were becoming essential not only for the education of doctors, but also for the advance of medical science. The difficulty in obtaining bodies for examination forced doctors to obtain bodies from graveyards. Generally the graves robbed were those of the poor, so that a special aversion to doctors grew up in the poorer sections of the large cities. The "Doctors' Mob" in New York in 1788 tried to lynch several doctors and students engaged in dissection, and the whole profession lost the confidence of the populace. The cause of medical education was put back substantially.[14]

Not until 1833 was dissection required at the School of Medicine of the University of Maryland,[6] although the actual implementation of this requirement may not have been accomplished until 1848.[15]

Dr. Charles Wiesenthal was completely committed to the importance of personal dissection of the cadaver by students as is shown in his letters to his son in 1781, while the latter was a student in Philadelphia:

> ". . . I see your beginning to dissect . . . which pleases me and insist that you continue to do the same manually in propria persona and not being content with merely demonstrations after the subject is prepared, as I want the practical part. It will lead you toward operations and will make that part of Surgery more intelligible."[10]

Sometime in 1788 Captain John De Corse was murdered on his packet in the Chester River by two hardened criminals, Patrick Cassiday and John Webb who were subsequently captured, tried, and executed. It seems probable that Dr. Wiesenthal obtained Cassiday's body from the state to use for dissection. A mob formed and forcibly took the body from the students at Dr. Wiesenthal's medical school. The school was not destroyed by the mob as occurred in 1807 when Dr. Davidge's Anatomical Theater was destroyed for the same reason by an angry mob.

Among Dr. Wiesenthal's students were his nephew, Frederick Dalcho (1770-1836), William Augustus Dashiel, George Buchanan (1763-1808), Ezekiel John Dorsey, and his son, Andrew Wiesenthal.

Dr. Wiesenthal's medical school seems to have been somewhat better organized than Dr. Brown's. The large dissection building and location in a growing city may have allowed better patient variety. At least two of the students went on to study in European Medical Schools; George Buchanan, MD, (University of Pennsylvania, 1785) studied with William Shippen and spent about three years in Edinburgh. Andrew Wiesenthal also studied with Shippen and spent some time in London in 1788, living with his aunt. The elder Wiesenthal was particularly eager to have Andrew break into print in the medical literature, and sent his own reports on "various Cases in Physic and will consider of some more, and I think I will likewise send you some of my Theoretical Opinions which you may be probably able to elaborate something farther and should it be worth the Notice of some of your friends it might be perhaps worth while to have it published, for this is the Truth that a great many more silly things have been published than what we should."[8]

Andrew outdid himself. Just prior to his death he sent a report from Baltimore to the London Medical and Physical Journal (2:204, 1799) of the first parasitic disease ever described:

> "Baltimore, in Maryland, May 21, 1797.
>
> "There is a disease prevalent among the gallinaceous poultry in this country, called the gaps, which destroy eight tenths of our fowls in many parts, and takes place in the greatest degree among the young turkeys and chickens bred upon old established farms. I know not whether the same kinds of fowls in England are liable to it, and therefore shall take the liberty to give you a brief account of it.

"Chicks and poults, in a few days after they are hatched, are found frequently to open their mouths wide, and gasp for breath, at the same time frequently sneezing, and attempting to swallow. At first the affection is slight, but gradually becomes more and more oppressive, until it ultimately destroys. Very few recover; they languish, grow dispirited, droop, and die. It is generally known, that these symptoms are occasioned by worms in the trachea. I have seen the whole of it completely filled with these worms, and have been astonished at the animal's being capable of respiration under such circumstances.

"The small figure represents the worms of their natural size, found in the trachea of chickens and young turkeys: the large figure, the same magnified. They are of a reddish colour, and at first view, resemble the human lumtricus; but when examined, are materially different. When exposed to the microscope, they are found to have orifice or mouth at one end, formed for suction; the other end, as far as I know, imperforated. Through the integuments is seen the intestinal tube, much convoluted, like that of the lumbricus.

"No effectual remedy is known against these most destructive animals. I have indeed seen them drawn out of the trachea, by means of a feather stripped from near its end, which is passed into the larynx, and twisted rounded till it engages one or two of the worms, which are extracted within it."

## ANDREW WIESENTHAL

Andrew Wiesenthal was appointed a physician to the Almshouse in 1789. Together with Dr. George Buchanan, he started a medical school in 1790. With other physicians of Baltimore he helped to establish the "Medical Society of Baltimore" whose principal end was the promotion of medical knowledge. A number of other physicians joined in the effort to create a medical school. Several had been trained in Philadelphia under Morgan, Shippen, Kuhn, and Rush at the first American medical school. They had undoubtedly been informed by Morgan's comprehensive medical reforms, the most important until the inauguration of the Johns Hopkins program in the 1890s. His reforms included the separation of physicians from the barber surgeons and apothecaries, the licensing of practitioners, a demand for academic training prior to medical school, and an emphasis on research.

In the *Maryland Journal* for March 29, 1790 appeared the following notice:

"The zeal for study and eager desire of requiring knowledge, that at present distinguish the students of medicine in Baltimore, have with much satisfaction been observed by some of the physicians of this place, who being desirous to aid and cherish as far in their power so laudable a spirit have entered into an association to establish a medical school here the ensuing winter, where youth who are engaged in the study of physic shall have opportunities of hearing courses of lectures . . . the advantages to be derived from a public hospital are too apparent to require illustration . . . At an early period of the ensuing winter courses of lectures on the following subjects will commence:

Anatomy, by Dr. Andrew Wiesenthal; Midwifery, by Dr. George Buchanan; Chemistry and Materia Medica, by Dr. Samuel Coale; Theory and Practice of Surgery, by Dr. Lyde Goodwin; Theory and Practice of Physic, by Dr. George Brown."

It may be hoped fervently that the good doctors' lectures were clearer and in better style than their announcement!

The Almshouse served an important part in the founding of the Baltimore Medical School. Wiesenthal's lectures continued in 1796 and 1797. Most unfortunately he died at 37 in 1798 as did Samuel Stringer Coale at 44. Thus ended the lives of two important and well-educated physicians in the prime of their careers.

Fortunately the Medical and Chirurgical Faculty, founded in 1799, took the organization of a school of medicine as one of its major purposes. In 1802, Dr. Philip Thomas, the President, recommended the adoption of the plan for a medical college (College of Physicians) but it was not until 1807 that the College of Medicine of Maryland, the fourth medical school in the United States, was incorporated by the State's General Assembly. It was not until 1810 that the first degrees of Doctor of Medicine were conferred on five candidates.

On Dec 31, 1796 Baltimore became a legally incorporated city.

The contribution made by the foreign-trained, young physician of the late eighteenth century to medical science in America was not so much an increased knowledge of disease, new therapeutic drugs, or new techniques of treatment or investigation; rather they brought back a new and higher conception of the physician's responsibility, new intolerance of inadequate medical training, new determination to improve opportunities for medical training in a hospital setting. In Baltimore they founded a medical society, started a medical school, and raised the stand-

ards of medical practice. These men were also the visiting men at the Almshouse hospital where they taught their students. In having a hospital-based medical school, they were following the example of the medical schools of the University of Pennsylvania, Columbia University, and Harvard. Harvard students were taught initially at the Boston Almshouse, but Pennsylvania and Columbia had hospitals in the modern sense.

* * * * *

A third example of a family style "medical school" was the one started by John Archer, MD, (1741-1810) the first graduate of an American Medical School (MB, University of Pennsylvania 1768). He was a classmate of Benjamin Rush at the Academy at Nottingham, Cecil County, as well as at Princeton College. Archer then went on to the Princeton Theological Seminary and entered the Presbyterian ministry. Because of a throat ailment he had to give up the ministry and was the first graduate of the University of Pennsylvania Medical School. He started practice at Churchville, Harford County, in 1769, and was active in the Revolutionary War. After the war his home ("Medical Hall") became the center of medical education in northern Maryland and adjoining states. He had three daughters and six sons, five of whom became physicians.

He was the first to advocate the prophylactic use of Peruvian bark in intermittent fevers. He used prophylactic vaccination against whooping cough.[16] He reported on the treatment of diphtheria.[17]

The Transactions of the Harford Medical Society 1797-8[18] is a manuscript collection of papers presented by Archer and his pupils, Robert Harris Archer, William Harris, George Washington Archer, Thomas Bayer, and A. Clendinen. The reports give a vignette of medical theory and practice of a group of physicians under the influence of Benjamin Rush, who appeared to be their patron saint. Disease was believed to be caused by increased stimulation. Treatment consisted of reducing excitation by depletion of blood (venesection), purging, increasing salivation (mercury), inducing vomiting, and sweating. Treatment failures occurred only when these measures were not used vigorously enough. They were a group of men obsessed by Rush's personal views who threw ordinary observation to the winds, and enforced their ignorance by self adulation.

* * * * *

Thus we have three examples of family "Medical Schools" developing out of the preceptorship system. Two had facilities for dissection and were established by graduates of foreign medical schools. These two schools were based on critical observation.

The last was the weakest because it depended on theory rather than critical observation.

Out of Wiesenthal's School grew the first Maryland proprietary school started by a group of specialists, but lasting for only a short time. It was on the European model of a number of professors and had a hospital as a source of clinical material. A very similar school founded 20 years later survived as the University of Maryland School of Medicine.

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Children do not "outgrow" crossed eyes. To prevent possible loss of sight, crossed eyes should be treated before the child reaches four years of age, counsels the National Society for the Prevention of Blindness.

# COMMUNITY MENTAL HEALTH AND THE MENTALLY ILL OFFENDER

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Despite a growing recognition of the viability of community mental health concepts in the prevention and treatment of mental illness, the application of these concepts with the mentally ill offender has progressed slowly and painfully. This article will describe a program in a maximum security hospital in which—through partial hospitalization, work and training opportunities, and the hospital's involvement in the community—patients are prepared for discharge and then provided with ongoing services to help them maintain themselves. The results of follow-up of 28 recently discharged patients are offered and those community mental health concepts found to be particularly helpful in their rehabilitation will be described.

## The Hospital

Clifton T. Perkins State Hospital, in which this program was developed, is a 246-bed maximum security hospital, providing evaluation and treatment services to male patients from all counties in Maryland. The hospital is often confused with the nearby Patuxent Institution where persons convicted of a crime and adjudicated defective delinquents are treated. In contrast, Clifton T. Perkins State Hospital is a mental hospital under the Department of Mental Hygiene; all of its patients meet the medical standards of involuntary commitment. Like Patuxent, however, the patients are considered dangerous and in need of maximum security. Patients are referred to the hospital by the courts and from other state hospitals and correctional institutions. Criminal action is pending in many of the case situations referred.

The program to be described in this paper grew out of the conviction of the superintendent and staff that the hospital needed to pioneer in community-oriented rehabilitative efforts in order to help patients make the doubly difficult transition from a maximum security setting to community living. Patients receive services in at least one of the program's three phases. The three phases consist of 1) patients working and receiving vocational training in the hospital while living in the hospital, 2) the partial hospitalization phase featuring work or training experiences outside the hospital, and 3) the community phase in which the client does not live in the hospital but continues to receive psychiatric, social, and vocational services. In most instances, the patient makes progressive moves through all phases of the program from full to partial hospitalization and then to discharge. There is also movement from training experiences to paid work. In particular instances, when the needs of the patients require it, certain of these stages may be bypassed. Also, patients who live in the community may be brought back if it appears that they would be a danger to themselves or others. They then begin anew the steps leading to discharge.

While in the hospital, the patients live in an area set aside for them. Two patients share a room and there is a recreation room featuring a pool table and television. There is a requirement that patients complete a successful work or training experience while fully or partially hospitalized. However, other than for this, the hospital program is a flexible one, incorporating both the expectation that the patient will improve and making allowances for his occasional regression when pressures become too severe for him. Plans for the release of the patient begin the moment he enters the hospital and come to fruition as he is prepared for discharge. Psychiatrists, psychologists, social workers, and vocational counselors continue to work with the patient in the community. The remainder of this article will present findings of a follow-up of recently discharged patients. The program also will

be described in the context of how selected concepts of community mental health can be operationalized with the mentally ill offender.

## The Follow-up

Since the program's inception in May 1966 until August 1971, 84 men have been discharged. Of these 84 men, 75 were discharged to their own families and nine were helped to make other kinds of living arrangements. All were supporting themselves either through their own earnings or in part by disability and other allowances. A follow-up study was conducted in the fall of 1971 of a recently discharged group of men in order to assess the effectiveness of the program in terms of two gross variables, rehospitalization and recidivism rates. All 28 men who had been released from the hospital during a 21-month period ending Aug 30, 1971 were followed up. All remained in the community at least four months. At the time of the follow-up study of the men discharged, 20 were still in the community without having committed a new offense and without requiring rehospitalization. Of the other eight men, seven had been rehospitalized at least once and one committed a new offense. In terms of diagnostic classification, 18 or the 28 men had been diagnosed as schizophrenic. In addition, 23 of the 28 had been found legally insane by various courts in Maryland.

As for those patients who did well in the community, ie, were not reinstitutionalized or did not commit a new offense, their diagnoses ranged widely from schizophrenia of various types of drug or alcohol addiction, retardation, severe neurosis, and chronic brain syndrome, singly or in combination. An interesting feature of the diagnoses of those who did well was that when a degree of intellectual retardation was found the patient seemed to respond especially well to a supportive, therapeutic relationship. Not one of these patients was rehospitalized or committed new offenses.

A comparatively greater proportion of men who were reinstitutionalized had had diagnoses involving paranoia or addiction to drugs or alcohol even though these diagnoses were also a feature of many of those who remained in the community. However, men who were rehospitalized or committed a new offense tended to be those who had histories of repeated institutionalization.

When seen in the context of their diagnoses and in light of the fact that all the men were suffering the consequences of a double stigma, that of mental illness as well as criminality, the performance of the men in the community may be seen as quite positive. Certainly, in terms of rehospitalization and recividism rates, the men who had benefitted from the program had done considerably better than comparable rates from conventional programs in the state and nationally. For example, a study of readmission rates in Maryland reported that at the end of 18 months, after hospital release, 45% of the psychotic patients had been rehospitalized.[2] The President's Commission on Law Enforcement provided similarly grim outcome statistics in their finding that roughly a third of those released from prison are reimprisoned, usually for committing a new offense, within a five-year period.[3]

The findings of this study with respect to recidivism, one patient of the 28 discharged, may thus be seen as particularly noteworthy. The authors believe that much of this success may be attributable to preventive intervention in the community. Such intervention may, however, lead to rehospitalization. In a situation in which both criminality and mental illness are important factors, the stance of staff members has been that "preventive" rehospitalization with a view to averting a possible crime may be considered a qualified success. The community mental health concepts which guided the staff's intervention will now be described.

## Community Mental Health Concepts

**Mental Health:** The philosophy of the program was guided by concepts of mental health which sees mental health as a function of personality and situation and not of personality alone. This view required focus on the patient's social functioning in crucial life roles. In its emphasis on work training, work experiences, and the acquisition of work skills and work habits, the program particularly addressed itself to one vital life role, although home visits provided opportunities to perform in other roles as well. The principle that adequate performance in one vital role leads to success in other roles was consciously applied in all planning with patients. The validity of this principle seemed to be borne out by the finding that of the 20 men in the community at the time of follow-up about 95% were working and functioning reasonably adequately. Moreover, of the eight others, seven had difficulties with employers or were unemployed when they were reinstitutionalized.

**Gradualism:** The concept of gradualism highlighted the patient's move from hospital to community in graduated steps. These steps called for carefully weighed measures of increasing self-dependence and self-reliance. At the same

time, there was a lessening of the highly restrictive controls typical of the maximum security institution as the patient progressed through the program. It should be stressed that even under maximum security conditions patients can be afforded privileges and given responsibilities. For example, rules pertaining to personal possessions were greatly liberalized in the program, and home visits were used as part of the therapeutic plan. The program sought to avoid the pitfalls of an overly-rigid delineation of steps leading to discharge because such inflexibility was found to retard rather than further the patient's move into the community. Thus, in situations where certain steps were bypassed, patients could move from a work experience back to training, or from partial hospitalization back to full hospitalization when this was necessary.

**Team Approach and the Milieu:** While in the hospital and after discharge, patients related to a number of mental health personnel in accordance with their needs and the expertise of the helper. These included psychiatrists; nurses and ward attendants; rehabilitation counselors specializing in education, vocational training, and job placement; social workers; psychologists; security personnel who acted as drivers taking the men to work or recreational activities; and other hospital employees, such as dietary and maintenance workers who supervised work and training assignments in the hospital.

A candidate for the program was most typically spotted by the attendant of one of the hospital's nine wards. Noticing a patient's increasing responsiveness, he or other professional and para-professional persons would try to interest the patient in the discharge program located in a separate part of the hospital. Patients were engaged in the formulation of a definite plan leading to discharge. This plan, implemented in stages as the patient gained self-confidence and social competence, was constantly kept in mind as patients progressed through the program. When the social situation inside or outside the hospital required it, plans were modified. Staff members also worked together in a coordinated way to establish and maintain contact with patients' families and with employers. Whenever possible, the effort was made to simulate in the hospital the kinds of situations found in the community so that patients were afforded the opportunity to become familiar with newly acquired responsibilities.

Group, individual, and family therapy were provided both inside the hospital and in the community as needed. In regular group meetings while in the hospital, the men were encouraged to make their own decisions relating to ward living, community activities such as supervised shopping or recreational trips, and discharge plans. Legal constraints as they intertwined with therapeutic considerations were, however, constantly kept in focus.

**Meaningful Work and Training Opportunities:** Because hospital staff maintained ongoing contacts in the community, skills acquired by the men could be meaningful related to the marketability of these skills. In addition to available high school or college courses, some men received training in such vocations as welding, car mechanics, upholstery, and carpentry. The training would be followed by job placement in these fields. Despite economic uncertainties, such placements could be effected in most instances. However, factory work and employment on various construction projects were also seen as valuable experiences adding to the patient's sense of competence. The development of positive work attitudes was a constant goal which could more easily be realized when the men felt a sense of achievement and pride in their work. Equally important was the considerable latitude afforded the men in the disposition of their income.

**Community Relatedness:** A high priority in the program was the maintenance of the link between patient and community. The goal to preserve, restore or enhance community ties was pursued diligently. Communication with the families of patients was kept open whenever possible to keep the family informed about the progress of the patient and to invite their active involvement in the patient's rehabilitation. Preparing for home visits and evaluating them was a constant theme in interviews with families and relatives as were more permanent discharge arrangements. Special emphasis was placed on helping the family see the patient as a person who could change if given the proper support.

**Stigma:** The concept of stigma is used here to draw attention to the severely-damaged self-concept of the person who has been hospitalized in a maximum security hospital.[5] Patients who were going through the program labored under the double burden of mental illness and criminality. Efforts to enhance the self-concept of patients did not rely solely on supportive encounters with staff, who would respond verbally to expressions of a defeatist attitude or similar frustrations stemming in part from the process of institutionalization. Efforts were also made

to tackle this problem experientially. For example, it was found that the experience of working, making independent decisions, visiting in the community, and enjoying increasing freedom from restrictions promoted and reinforced an image of self-respect, competence, and adequacy. Erving Goffman observed that patients who have discretion over their personal possessions are likely to have a higher-self-regard and a more positive attitude towards staff.[6] This principle was implemented whenever possible.

**Continuity of Care:** Continuity of care has been a much misused concept in community mental health in that it has often been misunderstood to mean lifelong dependence on a hospital. In the sense in which it was used in this program, continuity of care accented the hospital's responsibility to the patient. It was recognized that this responsibility was not always discharged most effectively by the hospital itself through ongoing patient contacts. Patients were referred to other agencies, such as community mental health centers, whenever possible. However, there was also a downtown clinic staffed by the hospital. The clinic continued to work with those patients for whom follow-up by the hospital was mandated by the court or when a local mental health clinic was inaccessible. By extending this arm of the hospital into the community, and by offering evening hours, it was often easier to intervene in crisis situations. Thus, the downtown clinic proved to be especially effective when rehospitalization was required.

**Prevention:** The preventive thrust of the hospital as a whole and of the program in particular may best be described in terms of its emphasis on primary, secondary, and tertiary prevention.[7] In the course of primary prevention, the staff of the hospital provided services to other agencies, such as prisons, the courts, and other hospitals with a view to averting a potential admission or at least shortening the period of hospitalization when it occurs. Primary preventive services included consultation as well as psychiatric evaluations performed for various court jurisdictions. The clinic's location in downtown Baltimore made it possible for staff members to be available as resource persons willing to provide consultation to other agencies about problems in which they had special expertise. As for secondary prevention, the focus of this type of intervention was mainly on the patient, his family, his employer, and on other significant environmental and hospital supports.

In secondary prevention, efforts were made to treat an illness which had already surfaced and to minimize regression, ie, to prevent the exacerbation of mental illness while preferably it was still in an incipient stage. Secondary prevention also focused on whatever measures were necessary to help the patient overcome a crisis. Patients were particularly receptive to appropriate therapeutic supports during such critical periods. The occurrence of crises could eventually be pinpointed. They tended to be at a point in time when job training was begun, when partial hospitalization was first initiated, and upon discharge. In tertiary prevention, emphasis was on helping the patient maintain himself after his situation had become stabilized in the community. Tertiary helping efforts were implemented by providing services at less regular intervals and by being accessible when it was felt that the patient had the strength to initiate contact on his own.

## Summary

In this article the focus has been on the partial hospitalization and community mental health aspects of a treatment program in a maximum security hospital. As part of the program selected concepts of community mental health were operationalized and a follow-up study, limited in scope but nevertheless suggestive, was conducted to assess the effectiveness of services offered. The application of community mental health concepts in work with the mentally ill offender, while beset with risks, nevertheless appeared to be sufficiently promising to warrant further development.

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# Socio-economic Correlates of Tetanus Immunization

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## Introduction

The recent emphasis on health maintenance in the delivery of health services places a major burden on the use of preventive measures to reduce morbidity in the population as a whole. Of crucial importance in the provision of such preventive services is an understanding of the factors related to the acceptance or avoidance of such services.

Tetanus toxoid immunization is a preventive service of proven value which has been generally available and promoted for over 30 years. The present study, part of a community-wide survey of immune status of the general population, provided a unique opportunity to examine the characteristics of users and nonusers of this preventive service as a model for future planning to reach under-protected segments of the population.

An important method of evaluating infectious disease control programs is the estimation of the immune status of a community. This is often attempted by counting numbers of immunizations given and cases of disease occurring in relation to the size of the population. However, neither of these events is apt to be reported completely or in detail and the total population is known with reasonable certainty only at or near the decimal censuses. More reliable and useful information is much more likely to be obtained by a community survey. This can serve three purposes: 1) to determine whether levels of protection are generally adequate; 2) to indicate which segments of the community are most in need of available immunizations; and 3) to estimate the potential need for immunizing agents currently in developmental stages.

Many immunization surveys have been limited to households of school-age children.[1,2] Although this group is undoubtedly important, it may differ in many characteristics from the rest of the population. To avoid this possibility, the present survey was based on a representative sample of an entire county.

## Materials and Methods

Washington County is located in western Maryland, and lies mostly in the Great Limestone Valley between the Blue Ridge and the rest of the Appalachian Mountains. A nonofficial census of the entire county in July 1963 enumerated 91,909 residents.[3] About 40% lived in Hagerstown, the major urban center and county seat, another 40% in rural areas, and 20% in the suburbs of Hagerstown or in scattered small towns. This geographic diversity, together with the availability of demographic and socio-economic information from the 1963 census and the ease of sampling households, led to the selection of Washington County for this study.

The sampling method was to select every hundredth household after a random start. Households in dwelling units existing in 1963 were selected from a list obtained in the nonofficial census; households in dwelling units built more recently were selected from building permits issued through May 1967 and filed in the Washington County Tax Assessor's office. Due account was taken of the fact that some buildings contained multiple households.

The survey was conducted during June and July 1967 by experienced interviewers. Questionnaires were completed for all but three of the 288 households in the sample. The informant was the head of the household in 84 instances, the spouse in 172, and some other person, usually an adult child of the household head, in 29. Interviews were conducted at home for 169 households, and by telephone for the remaining 116.

For all household members, information was collected on their immune status with respect to

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smallpox, poliomyelitis, measles, mumps, and tetanus. A person was classified as immune if he had recovered from a clinical case of the specified disease or if he had ever been immunized against it.

Some socio-economic and demographic data were also collected at the time of the interview. Additional information, including smoking habits, church attendance, and housing characteristics, was available for persons enumerated in the 1963 census.

## Results

In the 285 interviewed households, there were 936 individuals, or 3.3 persons per household. The distribution of the interviewed population by age and sex is shown in Table 1. The sex ratio was 93 males to 100 females, and the median age for each sex was 28 years. Only 27 of the total were nonwhite, 20 of whom were less than 20 years of age.

The reported levels of immunization against tetanus by age and sex are shown in Fig 1. Almost 90% of persons under the age of 15 had been immunized. After 15, the levels of immunization decreased with age to less than 20% after age 65. At nearly all ages, males were better immunized against tetanus than females, the differences being most striking after 30 years of age. Among males, there was a secondary peak at age 45, presumably the result of immunization in the Armed Forces in World War II.

**Table 1: Distribution of the Sample Population by Age and Sex**

| Age Group | Total | Males | Females |
|---|---|---|---|
| 0-9 | 209 | 106 | 103 |
| 10-19 | 168 | 78 | 90 |
| 20-29 | 116 | 54 | 62 |
| 30-39 | 105 | 57 | 48 |
| 40-49 | 131 | 60 | 71 |
| 50-59 | 86 | 43 | 43 |
| 60-69 | 63 | 27 | 36 |
| 70-79 | 37 | 19 | 18 |
| 80-89 | 16 | 5 | 11 |
| Not stated | 5 | 2 | 3 |
| TOTAL | 936 | 451 | 485 |

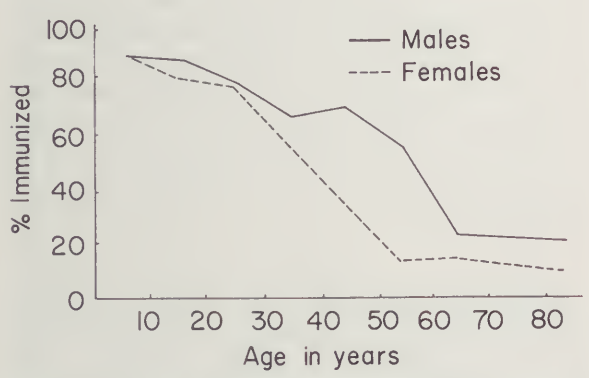



Figure 1: Tetanus immunization patterns by age in years and sex.

The socio-economic correlates of immunization are best studied for a disease sufficiently uncommon that the immune status of the population results almost entirely from artificial procedures. Although smallpox is now rare, it is not suitable because nearly everyone in the population had been vaccinated. Tetanus is also rare, and immunization against it has been generally available for more than 30 years. A history of immunization against tetanus, alone or in combination with diphtheria toxoid or pertussis vaccine, was given by about 70% of males and 60% of females in the sample. For these considerations, tetanus was selected to illustrate the association of socio-economic factors with immunization status. For the sake of homogeneity, further analysis will be limited to males.

Four socio-economic indices were used: 1) education of household head, measured as grades of school completed; 2) occupation of household head, in broad categories used by the US Bureau of the Census; 3) housing status, indicated by presence or absence of a complete bathroom; and 4) geographic location as urban, suburban, small town, or rural. The associations of frequency of tetanus immunizations and these indices of socio-economic status are shown in Table 2. Adjustments have been made for differences in the age composition of the subgroups.

There is a significant association with grades of school completed by the household head. If he had some college education, virtually all male members of the household had been immunized against tetanus. If the household head had had only a grammar school education, less than two thirds of the males had been immunized. The magnitude of this association remained approximately the same after adjustment for the other three socio-economic variables.

Although males living in a house with a complete bathroom were more likely to have been immunized against tetanus than those in a house with a partial or no bathroom, the difference was not significant after adjustment for differences in educational level. The highest rate of immunization was found in suburban areas and the lowest in small towns. Urban and rural rates were intermediate. After adjustment for differences in education of household head,

**Table 2: Per Cent of Males in Household with History of Immunization Against Tetanus, by Selected Socio-economic Indices, Adjusted for Differences in Age Composition**

| Category | N | Adjusted Per Cent |
|---|---|---|
| **Education of Household Head** | | |
| College Graduate | 34 | 100 |
| 1-3 years College | 23 | 96 |
| High School Graduate | 134 | 90 |
| 1-3 years High School | 92 | 74* |
| 8th Grade | 84 | 65* |
| **Occupation of Household Head** | | |
| Professional | 37 | 100 |
| Clerical and Sales | 21 | 98 |
| Managers | 62 | 97 |
| Service Workers | 26 | 94 |
| Craftsmen | 69 | 92 |
| Laborers | 23 | 88 |
| Operatives | 44 | 69 |
| Farmers | 30 | 49* |
| **Presence of Bathrooms** | | |
| With one or more bathrooms | 240 | 72 |
| No or partial bathroom | 81 | 63 |
| **Geographic Location** | | |
| Urban | 144 | 84 |
| Suburban | 45 | 91 |
| Small Town | 28 | 56 |
| Rural | 152 | 75 |

* $p < .002$, all other differences are N.S.

Note: Totals in each category differ because persons with missing information have been omitted.

**Table 3: DPT Status of Households with Children (<20)**

| Immunization Status of Children | Immunization Status of Parents: Neither | One or both | Total |
|---|---|---|---|
| None | 6 | 2 | 8 |
| Some | 12 | 5 | 17 |
| All | 37 | 94 | 132 |
| TOTAL | 55 | 101 | 157 |

$p < .001$

| | Father's Education: H.S. Grad | Non-H.S. Grad | Total |
|---|---|---|---|
| None | 0 | 8 | 8 |
| Some | 4 | 13 | 17 |
| All | 75 | 44 | 119 |
| TOTAL | 79 | 65 | 144 |

$p < .001$

this trend persisted, although the differences in urban and rural rates were not significant.

There was no association of frequency of immunization against tetanus with personal factors such as smoking habits or frequency of attendance at religious services.

Households with children under 20 years of age were studied to see which parental attributes correlated with immunization of children (Table 3). Children in households in which one or both parents had been immunized were more likely to have been immunized against tetanus than those in which neither parent was immunized. Similarly, if the father was a high school graduate, a greater proportion of the children were immunized than if he had not graduated from high school. Children from urban and suburban areas were somewhat more likely to be immunized than those from rural areas or small towns. No association could be detected between children's immunization status and family mobility, smoking habits of father, or adequacy of housing as judged by bathroom facilities.

## Discussion

Tetanus is unique among diseases for which widespread active immunization is practiced because there is no "herd immunity." The risk for an unvaccinated individual is the same regardless of whether few or most of his associates have been immunized. For this disease, immunization of all individuals in the community should be the goal. Neonatal cases of tetanus are diminishing, and the majority of tetanus cases now occur among adults, especially elderly persons with chronic diseases such as diabetes. In 1966, 57% of the cases in the United States occurred in persons over 40 years of age; the case fatality ratio also increased with age. Investigation of the cases reported in 1965 showed that virtually all occurred among persons with no prior tetanus immunization.[5]

Levels of immunization against tetanus in this sample were grossly inadequate, especially among persons over 30 years of age. Furthermore, the levels determined in this study probably overestimate the true situation because no account was taken of the length of time since last immunization. Although effective immunity against tetanus may in some cases last for at least 20 years after the basic series of immunizations, the recommended length of time between booster doses is ten years.[7] Because of the increased exposure to both accidents and tetanus experienced by farmers, it was particularly disquieting to find that they were the occupation group with the lowest levels of immunization against tetanus.

In addition to interest in tetanus immunization as a specific procedure, it may be regarded more broadly as a prototypic preventive health service, generally available through many sources and proven to be effective. Levels of immunization against tetanus may thus reflect to

some extent acceptance of other preventive health measures.[8] In this study, frequency of tetanus immunizations was related to socio-economic status, using education and occupation of the household head, adequacy of housing, and location of residence as indices.

The most consistently related socio-economic index was the education of the household head. Years of schooling completed by the head of the household were directly associated with the levels of immunization against tetanus, a relationship essentially unchanged after adjusting for the effects of the other socio-economic indices. This is consistent with previous findings.[9] Once again, it appears that preventive health services are most deficient among groups which can be presumed to need them most. However, to the extent that educational and immunization levels are causally related, hope for the future may be found in the fact that the proportion of the population with at least a high school education is increasing. In addition, specific programs designed to improve the education level of these sectors of the population may be necessary if preventive services are to be adequately utilized —a proposal which demands the serious attention of those currently planning health maintenance units.

Only two of the other socio-economic indices appeared to have an important association with levels of tetanus immunization. The low percentage of farmers with a history of immunization against tetanus has already been mentioned. Perhaps this results from their relative isolation from sources of health services and from the fact that these services are rarely available at convenient times. If so, it may be necessary to make preventive services available to them at unorthodox times and places.

Why immunization rates among suburban residents should remain high and rates among small-town residents low even after taking other socio-economic factors into account is not clear. Perhaps this is the result of the increasing numbers of rural nonfarm residents. Not only do these newcomers to rural living tend to live outside of the small towns, but they may have closer occupational, economic, and cultural links with the city than the farmer or small-town resident, thereby making it easier to obtain and accept health services that tend to be concentrated in and around the cities.

In any event, these observations strongly emphasize the fact that, within the community at large, substantial groups of individuals exist who are isolated from the mainstream of society by educational, economic, and geographic barriers. If they are to be provided adequate medical services, particularly services of a preventive nature, then as a first step, measures must be taken to identify them and to investigate the causes of their under-utilization of current health services. Only with such information can realistic programs be planned to correct these deficiencies in the current health care system.

## Summary

A survey of the immunization status of members of a 1% random sample of households in Washington County, Md is reported. Some 285 households were interviewed, comprising 936 individuals. Information was collected for all household members on their immune status with respect to smallpox, poliomyelitis, measles, mumps and tetanus.

Tetanus immunization levels showed a steady decline from childhood onward, with a secondary peak in males at age 45, and grossly inadequate levels in the older age groups.

Analysis of tetanus immunization in males revealed a progressive decline in immunization level with decline in socio-economic level. This was especially marked among households in which the head of the household had an eighth grade education and among farmers.

The implications of these results with regard to trends observed recently in this disease as well as to the delivery of preventive health services in the community at large are discussed.

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# Child Neglect and Abuse

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The Commissioner of the Baltimore City Health Department issued guidelines in September 1971 to physicians and hospitals for reporting medical emergencies. Among the list of medical emergencies, he included child abandonment, neglect, and abuse. The guidelines provided that the physician and hospital "immediately report by telephone to police in your city or county" all such cases.

Mr. Geoffrey B. Barnes, coordinator, Child Abuse Project, Sinai Hospital of Baltimore, Inc., made several positive comments relative to child protection and took exception with the Commissioner concerning the immediate involvement of the police, especially in cases of suspected child abuse. Mr. James Anderson, district supervisor of Special Services for the Baltimore City Department of Social Services, concurred with Mr. Barnes but cautioned physicians on "the need to use judgment regarding the immediate protection of children involved, and if there is real danger call in the police who can act with the necessary authority and dispatch required." John B. De Hoff, MD, deputy commissioner of health for the City of Baltimore, raised questions relative to the handling of these situations by the Department of Social Services, especially after normal duty hours.

Social workers, doctors, nurses, and other medical personnel have traditionally been the leaders in treating and protecting victims of neglect and abuse. This was best illustrated in a concerted effort to have the children suspected of being physically abused provided for under separate legislative fiat. Such incidents had in the past been considered a matter for law enforcement and provided for under common law assault and battery, but failure to prove beyond a shadow of a doubt that the alleged perpetrator did in fact commit a crime many times resulted in further endangering the child's life. It was recognized that both child neglect and abuse were family oriented problems manifesting inter-familial breakdown. Consequently a revised law was passed which introduced a new focus on mending the family whenever possible as opposed to ending the family for the child.

A frame of reference is being proposed for physicians and hospitals seeking community involvement for children suspected of being neglected or physically abused.

Under Article 88A, Section 3, of the Annotated Code of Maryland, the Social Services Administration has been designated as the central, coordinating and directing agency of all social service and public assistance activities in the State of Maryland, including Child Welfare Services. In order to carry out this responsibility, a Protective Services program has been established in each of the 24 local Departments of Social Services in cooperation with the local Juvenile Court to provide for the protection of children allegedly living in a neglectful situation.[1] Under this program and consistent with the statutes on juvenile causes a neglected child, generally speaking, is a person under the age of 18 years who is living in conditions hazardous to his physical or emotional health, well-being and development and whose parents are not acting to prevent or remedy the situation. The physician or hospital need only call the local Department of Social Services in the political subdivision where the neglect occurs to initiate an investigation.

The Protective Services Social Worker is responsible for determining the facts, evaluating the damage to the child, invoking the authority of the Juvenile Court whenever necessary and initiating appropriate social and rehabilitative services whenever possible that can help parents

1. Except in Montgomery County, Code, Article 26, Sec. 70-1 (j) provides: (j) "Neglected child" means a child who requires the aid of the court; and either 1) has been abandoned or deserted by his parents, guardian or other custodian; or 2) whose parent, guardian, or other custodian legally responsible for his care does not adequately supply him with food, clothing, shelter, education, medical, or other remedial care recognized by State law or other care or control although financially able, or offered the financial means to do so; or 3) who suffers or is likely to suffer serious harm from an improper home environment or guardianship, including the lack of moral supervision or guidance, of his parents, guardian or custodian. In Montgomery County a "neglected child" means any child who is destitute or homeless or abandoned or dependent upon the public for support or is without proper care and guardianship, or is unlawfully kept out of school, or mentally handicapped, or is found living in conditions endangering his physical or mental well-being.

improve their competence and capabilities in dealing with problems and conditions leading to the neglect of the child.

Under Code, Article 27, Section 35A (c), subtitle, "Child Abuse":

> "Every health practitioner, education, health, mental health, or social worker or law-enforcement officer, who contacts, examines, attends, or treats a child and who believes or has reason to believe that the child has sustained physical injury as a result of abuse, as by malicious beating, striking or other such cruel or inhumane treatment, shall make a report. . . ; provided however that if the education or social worker or law-enforcement officer or health practitioner examines, attends, or treats the child in the capacity of a member of the staff of a hospital, public health agency, child-care institution, juvenile detention center, school, or similar institution, the health practitioner, education or social worker or law-enforcement officer, shall immediately notify and give all necessary information required by this section to the person or persons in charge of the institution or a designated representative thereof, who shall make the report. . ."

A standard form (SSA-180) has been developed for reporting suspected child abuse consistent with the dual responsibilities of the local Department of Social Services and the local State's Attorney. Any physician or hospital without the forms should contact the local Department and request a supply. The original copy of the form should be forwarded to the local State's Attorney and a duplicate copy sent to the local Department of Social Services within 48 hours. An oral report to the local Department of Social Services is all that is needed to start an investigation. Moreover any physician or hospital making a report or participating in a judicial proceeding resulting from a report is immune from any civil liability that might otherwise be incurred or imposed in connection with the report.

The Protective Services Social Worker assumes the same responsibilities as in situations relative to child neglect but with the added responsibility of reporting the findings to the local State's Attorney's office.

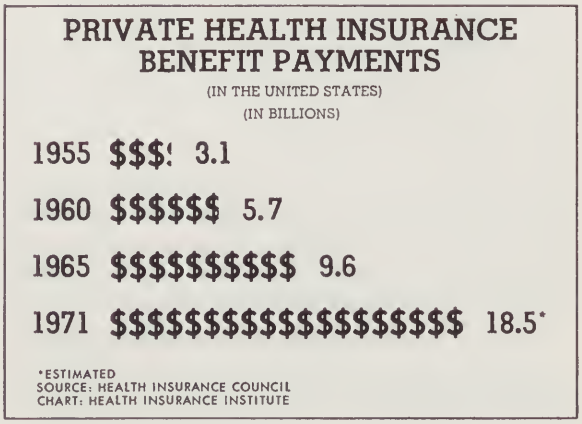
Whenever a physician or hospital believes it is in the best interest of the child who is threatened with a clear and present danger if left in the care of legally responsible relatives, law enforcement officers should be called. In all other situations, the local Department of Social Services should be viewed as the resource to whom physicians and hospitals turn for help in providing effective protection for the child suspected of being neglected or abused.

Every local Department of Social Services has an established listing of the names and telephone numbers of staff persons who can be contacted by physicians and hospitals after normal duty hours for the purposes of consultation and supportive help in utilizing the full resources of the local community on behalf of the neglected or abused child. The listing is provided both hospital and law enforcement personnel since these are the primary agencies providing 24-hour services and to whom neglected and abused children are usually referred.

In Baltimore City, the local department provides an additional service to the community. Staff are on duty between the hours of 5 PM and midnight, Monday through Friday at the Northeastern District Police Department. They will make home visits, if indicated, to determine whether or not Juvenile Court intervention is required to insure the care and safety of the child. Also, the Juvenile Court intake consultant is available at the same police department and can issue restraining orders whenever indicated. During the hours between midnight and 8:30 AM, Monday through Friday and on the weekend, the same staff is on standby telephone call and can be contacted through the Northeastern District Police Exchange whenever the services of the Department of Social Services are required.

Aside from financial and medical aid, the local Department of Social Services does provide, in most local subdivisions, Homemaker Service which could include 24-hour adult supervision for the child in his own home. In all 24 local subdivisions, if the need arises, the Department of Social Services can provide emergency and, long-term foster care, either on a voluntary basis or by Juvenile Court Order.

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# INITIAL MANAGEMENT OF THE MULTIPLY-INJURED PERSON

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The National Safety Council estimates that 105,000 civilian accidental deaths occur annually, 47,000 of which are due to vehicular injuries. The one millionth traffic fatality occurred in 1951; if the present rate continues, the two millionth victim will die in 1976. Although our traffic injury problem is colossal, it is estimated that only 15% of the nation's accidents involve automobiles. Accidents are currently the third commonest cause of death in the United States, being only slightly less than that from heart disease and cancer. Under age 40, trauma is the leading cause of death. We are annually experiencing 15 million injuries in children under 14 years of age, of which 15,000 are fatal.

One of the chief reasons for these dismal statistics is the inadequate provision of emergency medical care to accident victims throughout the nation because of:

1) Lack of organization of hospitals in accident handling, dilution of man power and resources.
2) Lack of adequately trained personnel in the average hospital emergency room to completely resuscitate, correctly diagnose and promptly treat severe injuries.
3) Lack of the "man in charge" in a multidisciplinary situation in dealing with the multiply injured person.
4) The fact that the intensive care and continued close surveillance which are necessary to maintain a critically ill patient are beyond the scope of the average practicing surgeon or physician.
5) Modern technological and medical advances currently available not being fully utilized in the care of the critically injured.

Intensifying the problem has been the virtual lack of information regarding the incidence, magnitude, and economic losses resulting from life-endangering injuries, as well as methods for monitoring proposed solutions.

A satisfactory outcome after severe traumatic injury is dependent upon two basic factors: availability of initial medical care and adequacy of early therapeutic measures. Injudicious or inadequate emergency management can cause unnecessary fatalities and permanent disabilities. The continually increasing incidence and magnitude of serious injuries resulting from high-speed transportation, complex industrial equipment, continued civil disturbances, and unpredictable mass catastrophies necessitate a reevaluation and reeducation of the priorities and techniques of trauma patient care.

The purpose of this paper is to outline these important priorities in the care of patients with multiple injuries with emphasis on the initial evaluation and management when they are first seen in the emergency department of a hospital.

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**Priorities:**

1) **Airway and ventilation**
2) **Hemorrhage**
3) **Catheterization**
   a) **Central venous catheter**
   b) **Gastric**
   c) **Urethral**
4) **Rapid but complete history and physical examination**
5) **Further evaluation of regional system injury**

#### 1) Airway and ventilation

The first and most important emergency measure in the management of the severely-injured patient is to establish an effective airway. In many instances, simple removal from the oropharynx of secretions, blood, food particles, loose teeth, or broken dentures may be all that is necessary to establish a clear airway. Maintenance of a clear airway is accomplished with an oropharyngeal or nasopharyngeal plastic or rubber airway. If this fails; then a cuffed endotracheal tube should be inserted under direct vision using an ordinary laryngoscope. Once airway is established, a means of positive pressure breathing is instituted either with an Ambu bag or a positive-pressure breathing machine. Before beginning mechanical ventilation, the presence or absence of a pneumothorax must be determined. In the presence of the latter, tube thoracostomy with

underwater seal will prevent the development or aggravation of a tension pneumothorax.

Emergency tracheostomy is seldom necessary in the traumatized patient except in the presence of middle facial fractures and open-floating fractures of the mandible where endotracheal intubation is difficult and hazardous. In the latter instance, the genioglossus muscle which ordinarily holds the tongue forward is rendered inactive due to the instability of its bony origin; as a result, retroposition of the tongue occurs. This, together with secretions and blood, may completely obstruct the upper airway.

Temporary airway patency in this situation may be obtained by forward traction of the tongue with the aid of a towel clip or a heavy silk suture placed through the tongue muscle using one or two cc of local anesthetic. Following this maneuver, an emergency tracheostomy may then be performed.

#### 2) Hemorrhage

The control of external bleeding is best accomplished by direct digital pressure or by the application of a pressure dressing or bandage. Ligation of superficial vessels which are easily visible is permitted but probing and blind clamping are to be condemned. Tourniquets are of little benefit in the control of arterial bleeding and are often injurious because they occlude collateral circulation and obstruct venous return leading to further tissue loss. (Exception: traumatic limb amputations.)

Prevention or correction of hypovolemic shock is best accomplished by starting intravenous infusions in at least two sites using No. 16 or No. 18 gauge needles or comparable size polyethylene catheters. The cephalic, basilic, or subclavian veins are usually the sites of preference for IV infusion. The lower extremities are avoided in the presence of abdominal wounds lest the inferior vena cava or its major tributaries are disrupted. The resulting outpouring of the resuscitation fluids into the retroperitoneal space would deprive the heart of much of the infusion being administered.

Blood for typing and cross matching is drawn at the time the initial I-V catheter is inserted. A balanced salt solution such as Ringers lactate or any available colloid such as plasma or dextran is usually started until type specific blood is available. The emphasis is on volume replacement rather than any specific solution.

#### 3) Catheterization

Immediately after providing for these emergency measures, the prompt insertion of a variety of indwelling catheters is necessary.

**A) Central Venous Catheter.** A centrally placed venous catheter is essential for the establishment of a reliable portal of fluid administration and it also provides a means of measurement of the central venous pressure. Measurement of central venous pressure is a valuable guide, along with other vital signs, in establishing and later monitoring the hemodynamic status of the patient. Such knowledge may be of vital importance in the presence of a chest injury since an elevated venous pressure may be an early clue in diagnosing pericardial tamponade.

The intravenous catheter is usually inserted either percutaneously or via a cut down to a vein either in the arm or the neck. If a cut-down is done, the use of a sterile silastic pediatric feeding tube is recommended. This type of catheter has advantage over the polyethylene type as it is less irritating and the incidence of phlebitis and thrombosis are low with its use. Careful aseptic technique should be used in the insertion of any intravenous indwelling catheter in order to avoid subsequent catheter sepsis. The catheter should be removed as soon as its use is no longer mandatory. X-ray localization of the catheter tip is also recommended because catheters inserted through arm veins tend to go up into the venous tributaries of the neck, hence giving false pressure measurements.

**B) Urethral Catheter.** A Foley catheter inserted into the bladder gives one valuable information in the early management of the trauma patient. The presence or absence of traumatic hematuria is established and urine is obtained for immediate urinalysis. The catheter is then attached to a urinometer for an accurate hourly measurement of urine flow. Inability to insert a urethral catheter in a multiply-injured person who is unable to void in spite of the urge to do so should make one suspect a ruptured urethra. Further attempts at forcing the catheter should be abandoned until such an injury is ruled out by a urethrogram.

**C) Gastric Catheter.** Insertion of a large bore nasogastric tube allows one to determine the presence or absence of blood in the stomach and also affords the opportunity to remove the gastric contents thus reducing the possibility of aspiration of regurgitated gastric contents. Although large food particles may not be recovered through the tube, the passage of the tube may provoke vomiting and empty the stomach of large particles. Gastric intubation also prevents gastric dilatation during anesthesia and aids in the prevention of postoperative distention.

#### 4) History and Physical Examination

After an adequate airway has been established and control of life-threatening hemorrhage has

been achieved the following information should be sought from the patient or, if he is unable to give a history, from members of the family, ambulance drivers, police, or bystanders at the scene of the accident:

a) What are the circumstances, force, location, type and time of injury?
b) What is the preaccident status and past history?
c) Is the patient diabetic, hypertensive, or cardiac?
d) Is he taking any medications, especially hormones?
e) Does he have any allergies?
f) Has he had previous tetanus immunization?

A complete physical examination including a neurologic evaluation is then rapidly undertaken.

#### 5) The Unconscious Patient

Patients with closed head injuries who are unconscious must have an airway established immediately. Head injuries, except when associated with severe scalp lacerations, are hardly ever the cause of shock. The presence of shock in association with a closed head injury is almost always due to blood loss in the abdomen or chest. The site of blood loss is most rapidly determined by chest and abdominal taps which may reveal the presence of nonclotting blood. The absence of blood, however, does not rule out an intraabdominal or thoracic injury and further investigation should be rapidly pursued.

A history of recent alcohol intake or the odor of alcohol on the breath should not be used as an excuse to label the patient as "being drunk" and hence overlook serious organic injury. Mild to moderate intoxication (blood alcohol 100-250 mg/100ml) [1] is reported to have no effect on the incidence of hypotention morbidity or mortality of surgical treatment for trauma. By comparison, levels of blood alcohol above 250mg/100ml do seem to influence these variables.

In evaluating a patient with a head injury, particular attention should be paid to the examinations of the head and face, cranial nerve function, level of consciousness, vital signs, and motor, sensory and coordination systems. Since neck injuries are commonly associated with head injuries, X-rays of the cervical spine should always be obtained when skull films are ordered on the unconscious patient. Should a neck injury be suspected by clinical examination, motion of the head and neck is avoided as much as possible and the patient should always be accompanied by a physician to the X-ray or to any other department.

### Chest Injuries

If a patient does not ventilate normally after a clear airway has been established, a chest injury should be considered. The majority of the more common chest injuries will be detected if the following simple questions are answered:

a) Is the chest wall intact?
b) Is there active respiratory movement?
c) Are the lungs expanded?
d) What is the central venous pressure?

#### 1) Pneumothorax

Dyspnea, hypotention, tracheal shift, subcutaneous emphysema, and diminished breath sounds in a hyper-resonant chest may indicate the presence of a pneumothorax. The chief causes of traumatic pneumothorax are penetration of the chest wall, laceration or perforation of the lung by an indriven fractured rib, or alveolar rupture secondary to blunt trauma.

If a doubt exists as to the presence of pneumothorax, an 18-guage needle may be inserted into the chest and aspiration done to determine the presence of air. Chest X-rays are preferable but respiratory distress often precludes time for X-ray confirmation. The treatment is tube thoracostomy connected to an underwater seal drainage system. A large diameter (28-32 Fr) intercostal catheter, preferably of the plastic type, should be inserted either in the 2nd intercostal space in the midaxillary line or in 5th space in the axilla. Small diameter or rubber tubes should be avoided, for they very frequently become occluded before the lung is fully expanded.

#### 2) Tension Pneumothorax

Tension pneumothorax is a much more dangerous condition than simple pneumothorax. In this situation the opening in the lung, chest, wall, or bronchus acts as a valve to allow air to enter the pleural cavity on inspiration but not to escape during expiration. As a consequence, pressure builds up within the pleural space. This elevated intrathoracic pressure collapses the ipsilateral lung, displaces the mediastinum, and significantly compresses the contralateral lung greatly augmenting venous return to the heart. Air hunger, hypotention, and cyanosis predominate the clinical picture. The treatment is again tube thoracostomy.

#### 3) Hemothorax

Rapid diagnosis of a hemothorax is made by thoracentesis in the 6th or 7th interspace in the posterior axillary line. Accumulation of blood in the chest may be minimal, moderate, or massive. No immediate special treatment besides thoracentesis is advisable in a minimal hemothorax. (300 cc-obliteration of the costophrenic angle). However, all patients with minimal hemothorax

should be closely observed in the hospital because bleeding may continue and progress to moderate or massive hemothorax within a matter of hours or days.

The treatment of moderate and massive accumulations is tube thoracostomy connected to a closed seal underwater system.

Since the diaphragm is frequently elevated as a result of a thoracic or abdominal injury, the intercostal catheter should preferably be inserted higher, in the 5th or 6th space in the posterior axillary line, to avoid misplacement of the tube into the abdomen. Inexperienced physicians should avoid trocar insertion of chest tubes. Instead, a small, one-inch incision is made, using local anesthesia and, with the aid of a blunt-nosed hemostat, the pleural cavity is entered. Pleural symphysis is excluded by introducing a gloved finger into the pleural space under sterile conditions. The tube is then introduced into the pleural space guided by a blunt-curved hemostat. Following introduction, the tube is securely fastened to the chest wall with a heavy suture and the wound dressed.

The commonest cause of a hemothorax is a lacerated systemtic vessel in the chest will (intercostal or internal mammary). Other sources of hemothorax include bleeding from injuries to the lung, heart, or mediastinal vessels, and from injured abdominal viscera with associated perforation of the diaphragm. Bleeding arising from the pulmonary circulation (torn lung) usually stops following expansion of the lung in contradistinction to the systemtic bleeding which may persist and necessitate operative intervention for hemostasis.

The indications for thoracotomy in massive hemothorax vary with different surgeons but as a rule the initial recovery of more than 1000 cc of blood from the chest cavity or bleeding at an hourly rate of over 200 cc are strong indications for emergency thoracotomy.

#### 4) Open Chest Wounds

Open chest wounds are obvious on inspection. These wounds are managed by immediate coverage with an occlusive dressing followed promptly by a tube thoracostomy. This prevents any further shifting of the mediastinum and allows ventilation of the opposite lung. Operative intervention is frequently necessary in the management of open-chest wounds.

#### 5) Flail Chest

Flail chest results when a segment of the bony thorax is fractured and mobile in more than one place, allowing the mobilized segment to move in a direction opposite to the rest of the thorax. Diagnosis is made by simple palpation of the flail segment or by observing the paradoxical movement. It is of the utmost importance that the injured victim be fully disrobed in the Emergency Room, otherwise an injury such as a flail chest may go unrecognized.

Where a small segment of the chest wall is involved, "active flail" may frequently be prevented by measures designed to minimize pain and to maintain a clear airway. Relief of pain by intercostal nerve block, frequent coughing, deep breathing, judicious and gentle suctioning all aid in the expansion of the lung, and prevention of accumulation of secretions.

Where a severe flail is already present, the proper treatment is clearance of the airway, tracheostomy, and positive pressure ventilation using a volume type mechanical respirator. This immediately expands the lungs, gives adequate ventilation, corrects anoxia and acidosis, and prevents atelectasis and pneumonia. Arterial blood gas determinations on admission and at frequent intervals thereafter are used as guide lines for proper management.

#### 6) Ruptured Bronchus

Respiratory distress associated with hemoptysis and pneumothorax or massive pneumothorax which persists following tube thoracostomy in a patient who has sustained a high chest injury should make one suspect rupture of a bronchus. If this is suspected, bronchoscopy and bronchography to confirm the diagnosis are strongly indicated following initial resuscitation. Early operative repair of this injury is necessary to prevent late untoward complications.

#### 7) Pericardial Tamponade

Pericardial tamponade is always the result of an intrapericardial injury secondary to blunt or penetrating trauma. All patients who have sustained crushing chest injury, gunshot wounds of the chest, and precordial or epigastric stab wounds should be presumed to have this injury until proven otherwise. Familiarity with this entity and a high index of suspicion of its presence will often lead to an early diagnosis.

Beck's triad of arterial hypotention, venous hypertension, and narrow pulse pressure are the classic signs of tamponade. These signs, however, may not always be present. The patient with tamponade may be restless, irrational, or comatose. Cyanosis is frequently present and the heart sounds are usually distant. Grunting respirations and reluctance of the patient to remain supine are characteristic. The pulse is weak or imperceptible and the arterial pressure is low or unobtainable. The venous pressure is often high and the neck veins are full; but, if there has been a great deal of blood loss, the venous pressure

may be low or normal.

Adjunctive diagnostic measures include direct measurement of the central venous pressure, chest X-ray, chest fluoroscopy, and EKG; in many instances the patient's poor condition precludes any such studies. Definitive diagnosis and emergency treatment is by pericardiocentesis using the subxiphoid approach with the patient in Semi-Fowler's position. An 18-gauge spinal needle connected to a 20-cc syringe may be used for this purpose. As little as 20 cc of aspirated blood may make a remarkable difference in the patient's condition and may be life saving.

However, patients who are fairly stable, but suspected of having tamponade, should be closely observed in the operating room or intensive care unit and pericardiocentesis performed under electrocardiographic control. This is easily done by placing a three-way metal stopcock between the syringe and a needle to which an EKG exploring chest electrode is connected. Electrocardiographic oscillation will be helpful in determining whether or not the myocardium has been penetrated or whether an abrupt change in cardiac action has occurred. Although routine thoracotomy and pericardiotomy is practiced in some centers for the relief of pericardial tamponade, individualization of each case and conservative treatment by repeated aspiration should not be abandoned.

#### 8) Aortic and Great Vessel Injuries

Aortic and great vessel injuries are, as a rule, the result of penetration by knife or bullet, and the majority of victims do not reach the hospital alive. Profound shock out of proportion to the injury present, associated with massive hemothorax, gives the clue to the diagnosis. Immediate thoracotomy offers the only chance of survival.

Aortic rupture from blunt trauma is a much commoner injury than one is led to believe. This usually occurs at the aortic annulus just distal to the left subclavian artery origin as a result of a decelerating injury. Less frequently the aorta may rupture at its root giving rise to pericardial tamponade and occasional rupture may occur at the diaphragmatic hiatus.

Effective surgical therapy is possible provided early diagnosis is made. In patients who are not exsanguinated soon after injury, a hematoma forms in the mediastinum and produces a characteristic X-ray appearance. When widening of the mediastinum is recognized on chest X-ray in a patient with a chest injury, serious consideration should be given to performing an emergency aortogram, for this is the only way the diagnosis can be firmly established.

### Abdominal Injuries

Patients with obvious abdominal injuries arising from blunt or penetrating trauma who are in deep shock require immediate laparotomy to control bleeding without any further investigation. Rapid clinical evaluation, typing and cross matching of blood, and catheterization of veins, stomach and bladder precede emergency laparotomy in these patients.

In these cases, anesthesia should not be induced until the entire operative team is fully gowned, masked, gloved, and the operative field fully prepared and draped. Massive blood replacement should take place during this period. The patient should then be anesthetized using a minimum of anesthetic agent and the abdomen opened rapidly using a generous midline incision from xiphoid to pubis. Induction of anesthesia in the presence of acute hypovolemic shock is a most critical period in the management of these patients and great care must be taken in order to salvage some of these desperate victims.

Other patients with injuries which offer no immediate threat to life should be carefully evaluated by repeated reexamination. Special attention is given to the presence of rib, spinal and pelvic fractures, abdominal tenderness, guarding, distention, and the presence or absence of palpable mass. Rectal examination should be done in all cases to determine the presence or absence of blood in the stool. Narcotic or analgesic drugs should never be given in patients suspected of having abdominal injuries since the varying degree of pain is one of the most important symptoms in arriving at a diagnosis and a course of action.

Nasogastric tubes and bladder catheters are often indicated in these patients as well as those who are more critically ill.

Once the vital signs become reasonably stable further diagnostic studies are done to determine the need for emergency operation or further observation. In addition to serial blood counts and urinalysis the following studies should be utilized:

#### 1) Chest and Abdomen X-Rays

X-rays of the chest and abdomen in the erect and supine position may serve to determine the course of missiles, the presence of foreign bodies, free air or blood, obliteration of normal shadows or displacement of organs from their anatomic position, and the presence of rib, spine or pelvic fractures.

#### 2) Intravenous Pyelogram and Cystogram

This study should be performed in all cases with significant blunt trauma to the abdomen,

traumatic hematuria, and all pelvic fractures. The absence of hematuria does not rule out urinary tract injury. In one large series[2] of patients with urinary tract injury, 41 patients had no evidence of either gross or microscopic hematuria. Of these 13 had a kidney pedicle injury, ten had a major parenchymal kidney injury, and 18 had a minor parenchymal kidney injury.

Cystography and pyelography should be done at the same time that other emergency X-rays are obtained, following adequate resuscitation of the patient to a stable level with a systolic blood pressure of at least 100 mm Hg. Visualization of the kidneys is futile in the presence of hypotention. In cases of massive intraabdominal hemorrhage necessitating immediate laparotomy, the patient should be placed on an operating table equipped with an X-ray cassette so that an intravenous pyelogram may be obtained intraoperatively following the arrest of threatening hemorrhage and stabilization of the patient's condition. The infusion method of pyelography is preferred. One single 15-minute film is usually adequate to determine function of the kidneys as well as to indicate extravasation from the ureter or kidney. Should a nephrectomy be necessary during a laparotomy, a functioning kidney on the opposite side should be demonstrated.

The cystogram is performed by the instillation into the bladder of 150-300 cc of contrast material (cystokon or hypaque diluted 50-50 with sterile saline) through the indwelling catheter until the patient has the urge to void. The catheter is then clamped and films obtained in the antero-posterior lateral, and oblique positions. The bladder is then allowed to empty and the same views repeated. A cystogram such as that obtained from an intravenous pyelographic study is not adequate for evaluation of the bladder. A number of instances have been observed in which an IVP was obtained following blunt abdominal trauma with a normal appearing bladder and without evidence of extravasation in patients who subsequently turned out to have significant bladder tears.

#### 3) Paracentesis

Paracentesis is most helpful in the diagnosis of intraabdominal injury in the comatose patient and in the patient with multiple-system trauma. Routine paracentesis is probably unnecessary; when there are penetrating abdominal wounds, it is superfluous. A simple and rapid technique of performing a diagnostic paracentesis is to attach an 18-gauge needle to a 10-cc syringe and introduce the needle through the abdominal wall on each side of the abdomen lateral to the rectus muscle midway between the costal margin and the iliac crest. This area of the abdominal wall is devoid of major vessels and, since free blood and fluid accumulate in the flanks with the patient supine, the chance of aspiration of free intraabdominal blood or other fluid is enhanced. Constant suction is maintained on the plunger during the procedure. The tap is considered positive if nonclotting blood is obtained. Should fluid instead of blood be aspirated it should be sent to the laboratory for amylase determination. A negative (dry) tap is of no diagnostic significance.

#### 4) Serum and Urine Amylase

Elevation of the serum amylase usually follows injury to the pancreas and the adjacent duodenum. Since both of these organs are retroperitoneal and difficult to evaluate by clinical methods, early diagnosis is often possible by detecting abnormal amylase levels in the blood, urine, or peritoneal fluid. Serum and urine amylase should be determined routinely in all patients with significant blunt abdominal trauma on admission and every eight hours thereafter during the observation period.

In the author's experience, elevation of this enzyme in blunt abdominal trauma associated with even minimal clinical abdominal findings denotes duodenal or pancreatic injury. In a prospective study now in progress[3], 72 consecutive patients with blunt trauma to the abdomen had amylase studies performed. Of these, three patients demonstrated high amylase levels on admission with subsequent elevation of the enzyme over the admission value in both the blood and the urine. At operation, two patients were found to have multiple fractures of the pancreas and one, a child, had an intramural hematoma of the duodenum.

Serial determination of this enzyme following surgery or trauma is also helpful in the detection of complications such as fistula, pseudocyst, and postoperative pancreatitis.

### Peripheral Vascular Injuries

The recognition of a major vascular injury in an extremity which has sustained blunt trauma, or in one which is not visibly bleeding, is not always easy. A vascular injury should nonetheless be suspected in any patient who is in shock, has a penetrating wound, or has suffered significant blunt trauma such as a fracture. Physical examination with special attention to pain, paresthesiae, pallor, paralysis, and pulselessness (5 Ps) is of extreme importance in the diagnosis of major vascular injuries, although a major vascular injury may occasionally be present without any of these signs.

Proximity of a wound to a major vessel is important. A bullet need pass only within a few centimeters of a vessel in order to cause contusion and subsequent thrombosis. Distal pulses may be present under these circumstances on initial examination only to be absent at a later examination. A questionable pulse is an absent pulse.

Expanding and pulsating hematomas denote underlying vascular injury and demand surgical exploration even though a distal pulse may be present. A hematoma, irrespective of size, seldom produces sufficient compression of an artery to cause loss of a distal pulse, except in a closed compartment when pulse pressure is low because of associated hemorrhage.

Arteriography is of great value in the definitive diagnosis of arterial injuries when the signs of such injuries are not clear cut. This is especially so in blunt trauma and fractures. Arteriography is unnecessary and even undesirable in the obvious massively bleeding wound. The Sedlinger percutaneous arteriographic technique is recommended. Following injection of the contrast media, films should be obtained in the anteroposterior, lateral, and oblique positions. A diagnosis of arterial spasm made by arteriography should be rejected and arterial injury taken as the diagnosis. In most instances where acutely injured vessels appear to be in spasm, arterial contusion with thrombosis or intimal disruption is present.

## Fractures, Soft Tissue Injuries

All obvious extremity fractures should be promptly and properly splinted. Thomas splint for the femur, air or pillow splint for the leg, and ankle and arm board or air splint for upper extremity fractures are recommended and are easy to apply. Proper splinting relieves pain, improves circulation, prevents further tissue damage, and prevents a closed fracture from becoming an open one.

Examination of the extremity distal to a fracture or a wound is imperative to determine the circulatory and neurologic status of the limb. Dislocations associated with severe circulatory insufficiency should be reduced in the Emergency Room as soon as possible without anesthesia. Injections of drugs and intravenous fluids should not be given into an injured extremity. Abdominal and chest injuries with shock or impending shock take precedence over fracture treatment unless there is an associated major vascular injury. Pelvic fractures are managed conservatively with bed rest and pelvic sling or traction depending on the severity. Since pelvic fractures are very commonly associated with hemorrhage and urinary tract injuries, typing and cross matching for large quantities of blood as well as IVP and cystogram are strongly recommended.

Major open wounds are quite obvious. Dressings or bandages applied by the first aid ambulance team, or at another institution, are removed merely for observation of wound extent and inspection for bony, nerve, tendon, or vascular injury. Bulky dressings are then reapplied and definitive care is planned in the operating room.

Minor wounds could be explored, debrided, and definitively treated in the emergency room. However, should a vascular, nerve, or tendon injury be encountered at exploration of such a minor wound, further treatment is abandoned, a dressing applied, and definitive repair planned under optional conditions in the operating room.

### Facial Wounds

Skin, soft tissue, and bony injuries of the face are, as a rule, not life threatening and can afford delayed treatment. Skin closure may be delayed four or five days and fractures up to three weeks, with the exception of nasal fractures and fractures in children, which tend to undergo early fibrous union. This is not ideal treatment; but, in dealing with a patient who is multiply or severely injured, these injuries are of low priority. The only real emergencies arising from facial wounds are airway obstruction, nasal bleeding, and eyeball injuries. Airway obstruction is relieved by any of the methods outlined earlier, nasal hemorrhage is controlled by packing, and eye injuries evaluated by an ophthalmologist as soon as possible.

Temporary care of facial wounds is accomplished by wet-dry dressings; application of a firm, even-pressure bandage; and elevation of the head. Blind clamping and probing of facial wounds, especially in the area of distribution of the parotid duct and facial nerve, is prohibited.

## Summary

Trauma is a major public health problem and, as such, it is inadequately handled in our community. Persons with life-threatening injuries require prompt and judicial care in the immediate post-injury period. Priorities in the management of such persons have been outlined and methods of early diagnosis and treatment of regional system injuries are proposed.

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"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."

John Galsworthy

FREDERICK J. BALSAM, MD, Editor

rehabilitation medicine

# CALCINOSIS UNIVERSALIS

## Review of the Literature and Report of Three Cases

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Calcinosis universalis is a rare disorder of unknown etiology, characterized by formation of calcium deposits in the skin, subcutaneous tissue, muscles, tendons, and, occasionally, nerves. The disorder is often associated with dermatomyositis, scleroderma, and other collagen diseases. The calcium formations observed consist of calcium phosphate and calcium carbonate and have the physical and chemical properties of normal bone.

The literature abounds with theories about etiology and management, but no satisfactory method of treatment is available. Spontaneous recovery and a reversible process have been reported occasionally.

### Review of the Literature

Teissier[1] was the first to report a case of calcinosis universalis. His doctoral thesis, published in 1876, describes the disorder in a 21-year-old woman. In 1878 Weber[2] reported a case associated with scleroderma. In 1907 Krause and Trappe[3] reported a case of generalized calcinosis which differed from myositis ossificans. Clara[4] published an excellent bibliography in 1950.

**Etiology.** No single theory fully explains the changes observed in calcinosis universalis. It is frequently argued that the disorder is due to changes occurring in the collagen tissue. Fanconi and Rossi[5] go so far as to classify calcinosis as a collagen disease. A number of investigators feel that injury to collagen tissue, originating within the tissue or outside it, plays a key role. Bahverstedt[6] believes "tissue suffering" causes calcification. Hamlin[7] and Jadassohn[8] mention inflammatory infiltrates. Others believe that skin lesions caused by repeated irritation (for example, hematomas and tumors caused by intramuscular injections) are contributing factors. Scott[9] reports the case of an 11-year-old girl who developed calcium nodules in her leg four months after a fall caused bruises at the same site. Why is it, though, that calcinosis does not occur in all cases of injured tissue?

Metabolic theories of etiology have been proposed. Sunderman[10] studied a patient who had calcinosis despite negative calcium balance and a restricted calcium diet. This case supports the view that calcinosis is not associated with normal response to calcium deprivation. Sunderman concludes that the pathogenesis of calcinosis involves abnormal affinity of the mucopolysaccharides of ground substance for calcium. This affinity may be related to nutritional or hormonal factors. In most cases results of serum calcium and phosphorus studies are normal.

Endocrinologic theories relate calcinosis to dysfunction of several glands, including the thymus, gonads, hypophysis, parathyroid, and adrenals. Clara[4] believes degeneration of any of these glands may be secondary to calcinosis. Ronconi[11] reports a case of calcinosis universalis that improved during pregnancy.

Vasomotor theories have strong supporters in Thierberge and Weissenback,[12] Zellweger,[13] and others because some forms of calcinosis are associated with Raynaud's disease, which causes tissue anemia and predisposes to deposition of calcium salts.

**Diagnosis and Management.** The diagnosis of calcinosis universalis is best made by X-ray studies, which show calcific deposits in the soft tissues of the extremities but not in the visceral wall. Atkinson and Weber[14] identify two types of calcinosis: calcinosis universalis, which involves widespread areas, and calcinosis circumscripta, which is localized to hands and feet and around large joints. This classification is purely descriptive and indicates primarily the severity of involvement.

Symptomatology varies. Usually there is generalized malaise with joint pain and stiffness. Calcifications in the skin and subcutaneous tissue may ulcerate, with a chalky and sometimes purulent discharge. The ulcers drain and then heal by scarring. Flexion contractures, disuse atrophy, and weakness are almost always present. Weakness is usually proximal and symmetrical.

Calcinosis universalis is most commonly found in children and young adults, but the disorder also occurs in older adults. It is more frequent in females than in males. The youngest patient reported is a two-month-old infant.[15]

Muller[16] reviewed 118 cases of dermatomyositis admitted to the Mayo Clinic between 1945 and 1955. The female-to-male ratio was three to one. Twelve of 87 adults had calcinosis universalis; 17 of 31 children had it. The prognosis was better for patients with both calcinosis universalis and dermatomyositis than it was for those with dermatomyositis alone.

Wheeler[17] presented data on 12 cases of soft tissue calcification and discussed 54 additional cases reported in the literature between 1938 and 1951. He found ten cases with "no apparent primary disease." The rest were associated with collagen disease, usually dermatomyositis or scleroderma.

Because calcinosis universalis appears to be related to collagen disease, steroid therapy is usually the treatment of choice. Chelating agents, ammonium chloride, sodium acid phosphate, ketogenic diets, aluminum hydroxide, calcium deprivation diets, and, recently, sodium etidronate[18] have also been used. Concomitant use of heat therapy and exercise has been found helpful and essential.

## Case Reports

**Case #1** was a white female born in January 1955. In December 1960 she was admitted to the Institute of Physical Medicine and Rehabilitation, St. Francis Division, Peoria, Ill. The child had a four-month history of generalized muscle weakness, joint pain, and flexion contractures around weight-bearing joints. She had lost considerable weight. Neurological examination was negative. She responded to conservative measures including hydrotherapy, range of motion exercises, and a muscle reeducation program. She became independent and was able to ambulate fairly well. When she was discharged in May 1961, the diagnosis was nonparalytic polio or rheumatic fever. The early history of the case is incomplete since the child was abandoned by her divorced parents and adopted by her grandparents. There is a possibility of mistreatment, deprivation, and neglect.

Other admissions followed in 1962-63. There were increased symptoms including erythematous areas and widespread, symmetrical, small, subcutaneous nodule formations which ulcerated with white, chalky, purulent drainage. The ulcers healed with scar formation. X-rays showed generalized osteoporosis and calcinosis mostly in proximity to weight-bearing joints (See Fig. 1-6). During voluntary muscle contraction electromyographic studies showed myopathic potentials of short duration with amplitudes as low as 400-



Fig 3: Lateral view of the left knee and thigh showing calcifications (Aug 1964).




Fig 4: Chest X-rays showing soft tissue calcifications (Aug 1964).



Fig 1: Showing soft tissue calcification in the lower abdomen, pelvis and upper thigh areas (Nov 1962).



Fig 2: Increased soft tissue calcification and osteoporosis in upper legs and hips (Aug 1964).



Fig 5: Showing calcification of the biceps and triceps (Feb 1969).



Fig 6: 1969 lateral view of the knee. Calcifications are evident.

500 uv in the proximal muscles. No denervation fibrillation potentials were observed when muscles were at rest. The diagnosis of dermatomyositis was confirmed at this time by the clinical picture and hematological studies of enzymes, sedimentation rate, serum, and electrophoretic patterns.

The patient was given methylprednisolone; the initial dosage of 4 mg/day was increased to 12 mg/day. No biopsy was done. Because calcifications were present, the diagnosis was calcinosis universalis. Hot packs and Hubbard tank treatments were used as indicated. At times Buck's traction was applied to stretch contractures. The patient did range-of-motion exercises regularly. Depending on her status, she was assisted with forms of ambulation ranging from walking in the pool to using a walker or crutches.

A chelating agent, calcium disodium edetate, a total of 15 intravenous injections over a period of three weeks, did not change the course of the disease. Laboratory studies showed little or no elevation of 24-hour calcium excretion in the urine. Serum calcium and phosphorus values were normal.

During a 10-year follow-up, the patient had multiple remissions and exacerbations. She was helped to some extent by a rehabilitation program and steroid medications. Because of severe contractures in the lower extremities, she became dependent upon a wheelchair. She was homebound but able to care for personal needs without assistance. She had a tutor and received therapy through the Visiting Nurses Association. Complications such as intestinal bleeding, nephrolithiasis, and hydronephrosis were life-threatening, but surgery was not performed. It was discovered that the patient had a long kidney and double ureter on the left.

Surgery for acute appendicitis was successful. Final hospitalization was complicated by severe pancreatitis, bronchopneumonia, and electrolyte imbalance. The patient died on Jan. 19, 1970, three days after admission, at the age of 15.

There are several interesting points in this case. It shows, for example, how the onset of calcinosis universalis and the subsequent appearance of nodules can simulate rheumatic fever, rheumatoid arthritis, and other collagen diseases. The case history calls to mind the injury theory of etiology because there is a possibility that the patient was mistreated during early childhood. Finally, it should be noted that there was a duplicating anomaly of the left urinary tract that would usually warrant routine genitourinary studies.

**Case #2** is a Negro female born in December 1962. She has been followed at Children's Hospital in Washington DC since September 1969. The diagnosis is calcinosis universalis complicating dermatomyositis.

At the age of three and one half the patient developed an erythematous rash over the elbows and upper eyelids, intermittent low grade fever, generalized joint stiffness, and increasing difficulty in bending over, climbing stairs, and ambulating. The symptoms were worst in the early morning hours. Palpable subcutaneous nodules developed generally but were especially profuse over both knees, left arm, both thighs, and both shins. Some nodules opened and drained a chalky white material. Flexion contractures developed in hips and elbows.

The family history is remarkable in that the patient's mother had systemic lupus erythematosus. The mother died in 1969, and autopsy confirmed this diagnosis.

The diagnosis of dermatomyositis in the child was based on muscle biopsy and laboratory studies. Electromyography showed diffuse myopathy, more severe proximally than distally. In 1969 X-rays showed calcific deposits in soft tissues of the upper and lower extremities. Previous X-ray films made in 1965 to diagnose a fractured femur showed no calcifications.

The patient was started on prednisose I mg/kg/day and was maintained with a dosage of 7.5 mg daily. The medication was discontinued in October 1969. Laboratory data such as blood count and chemistry studies were correlated with steroid management. Clinically, the nodules first became smaller, then grew larger again. Heat and exercise helped to maintain function. Remissions and exacerbations were treated accordingly. A chelating agent, calcium disodium edetate, was not effective. X-rays continued to show multiple tissue calcifications, demineralization of bones, and fractures of interphalangeal joints of the second, third, fourth, and fifth fingers of the left hand.

In January 1971 the patient was placed on sodium etidronate, an experimental drug thought to prevent further calcifications in abnormally calcified tissues.[18] The maintenance dose of 200 mg/day is taken between 7:00 AM and 8:00 AM. Dairy products are excluded from the patient's diet until 10:00 AM.

The child is on this regimen at the present time. She attends a school for the physically handicapped and receives occupational and physical therapy. For medications and laboratory

studies she is followed as an outpatient at Children's Hospital.

Clinical and X-ray findings indicate that she is not developing new lesions and that many of her old lesions are draining and healing. She has shown definite improvement in range of motion, remaining in the Class II status suggested by Steinbrocker[19] to describe degrees of functional impairment. Class II indicates normal activities despite discomfort or limited motion of one or more joints.

Several points are worth noting in this case. The patient's mother died of systemic lupus erythematosus. Was this coincidence or is there a relationship between this collagen disease and calcinosis universalis? Six months before the first appearance of symptoms, the patient fell and broke her femur. Does this injury have any bearing on the etiology or pathogenesis of her condition? The patient has not been taking steroids for two years. During this period of time she has improved, or at least not gotten worse, which was not the case while she was on steroids. Do steroids, which are often used to treat collagen disorders, act in any way to make existing calcinosis worse or to create new calcifications? Is the research drug sodium etidronate helping, or is this patient one of the rare ones who go into a state of remission with reversible changes?

Case #3 is a white male born in December 1962. He has been followed in the Department of Physical Medicine and Rehabilitation, Georgetown University Hospital, Washington DC, since 1966. The diagnosis of dermatomyositis was confirmed by muscle biopsy after appearance of classical clinical picture including erythematous rash over the face, knuckles, and eyelids; marked weakness; severe pain in the right knee; and dysphagia.

The child responded to high doses of prednisone with dramatically increased strength. However, after one and one half years, he started to deteriorate with subcuteaneous calcifications, cellulitis, abscesses, vasculitis, and severe osteoporosis. In May 1969 multiple collapsed vertebrae and several joint contractures made him unable to ambulate. X-ray therapy for severe back pain brought no improvement. Hepatomegaly, ascitis, gastrointestinal bleeding, and hypertension followed. Recent X-rays show calcinosis universalis. Among other complications, bilateral cataracts thought to be due to steroids have been discovered. During several admissions to the hospital, serum calcium and phosphorus studies were within normal limits.

Prednisone dosage has been lowered to 17.5 mg/day. Soon the child will be placed on immunosuppressive medications. CPK and electromyographic studies indicate that the disorder is decreasingly active.

A stepped-up rehabilitation program is bringing fair results. The child can now move about free of pain in the whirlpool and is starting to bear some weight on his legs in the whirlpool. His strength has improved slightly, but he is not yet able to stand except in the water. In his Taylor back brace he can tolerate elevation on the tilt table to an angle of 45°. At the beginning of this course of treatment in June 1971, he could not be moved except by his mother, could not be moved without a brace, and could not sit at more than a 30° incline. He had an acutely painful "china doll" back. Now he is happy, moving easily without pain, and far more active.

## Summary and Comments

The three cases presented are similar in several ways. All three patients first showed signs of dermatomyositis and later developed signs of calcinosis universalis. The authors believe that if some of the cases reported in the literature as idiopathic were followed long enough, the presence of collagen disease would be detected.

In the three cases we studied, serum calcium and phosphorus values were normal, but enzymes increased when calcinosis universalis was in an active stage. Electromyography showed a myopathic pattern more proximally than distally during active muscle contraction. Both radiographic and biopsy studies showed marked osteoporosis and soft tissue calcifications. Autopsy in one case and biopsy studies in the other two cases confirmed the diagnosis of dermatomyositis.

All three patients were treated with steroids. Dosages and results varied. Two patients were given chelating agents, and one was given sodium etidronate. One patient will be placed on immunosuppressive medications in the near future.

One question we would like to raise is whether or not steroid therapy, which was used in all three cases after the diagnosis of dermatomyositis was made, had anything to do with the subsequent increase in calcinotic lesions. In this regard, the second case is especially interesting and puzzling. Was improvement due to discontinuing steroids, sodium etidronate, or a remission?

All three patients benefitted to one degree or another from rehabilitation procedures. Jaramillo[20] reports two cases of calcinosis universalis associated with dermatomyositis. One patient was helped by a rehabilitation program similar to the ones described here, showing improve-

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ment in osteoporosis, reduced calcium deposits, and decreased disability. Jaramillo stresses the importance of early referral to physical medicine and rehabilitation.

Current knowledge of calcinosis universalis is incomplete. More follow-up, more teamwork among specialties concerned, and above all more research are needed.

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*Information and reprint requests to Dr. Kenrick.*

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*—George Sarton, from "The History of Medicine Versus the History of Art"*

# Would it be useful in clinical practice to have government predetermine drugs of choice?

# Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

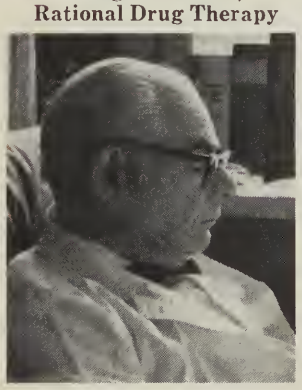
86.7%
No, it would not be useful.

# Dialogue

# Would it be useful in clinical practice to have government predetermine drugs of choice?

## Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really b determined.

The Bureau of Drugs h suggested the package i sert as a possible means communicating informati on relative efficacy of dru to the physician. I find th objectionable, since I c not believe the physicia should have to rely on th source for final scientif truth. There is also a pra tical objection: Since fe physicians actually di pense drugs, they seldo see the package insert. I any event, I would mai tain that the physicia should know what drug h wants and why without d pending on the governme or the manufacturer to te him.

Undoubtedly, physician are swamped by excessiv numbers of drugs in som therapeutic categories. An I am well aware that man drugs within such cat gories could be eliminate without any loss, or pe haps even some profit, t the practice of medicin But, in my opinion, neithe the FDA nor any oth single group has the expe tise and the wisdom nece sary to determine the or "drug of choice" in a areas of medical practice.

# Maker of Medicine

enneth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
Eli Lilly and Company



In my opinion, it is not
e function of any govern-
ent or private regulatory
ency to designate a "drug
choice." This determina-
on should be made by the
ysician after he has re-
ived full information on
e properties of a drug,
d then it will be based on
s experience with this
ug and his knowledge of
e individual patient who
seeking treatment.

If an evaluation of com-
rative efficacy were to be
ade, particularly by gov-
nment, at the time a new
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arketing, it would be a
eat disservice to medi-
ne and thus to the patient
the consumer. For exam-
e, when a new therapeu-
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e basis of limited knowl-
ge, it may be considered
be more potent, more
fective, or safer than
oducts already on the
arket. Conceivably, at
is time the new drug
uld be labeled "the drug
choice." But as addi-
onal clinical experience is
cumulated, new evidence
ay become available.
ater, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audio-visual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin $B_{12}$ as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

## Opinion & Dialogue

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*An arrangement is about to be consummated by which the Library will be opened every day.

# 1848, 1972

In browsing through some of our historical records, we found a copy of the Library Bylaws bound with the *Act of Incorporation and Supplementary Acts with the By-laws of the Medical and Chirurgical Faculty of Maryland, to which is added a List of the Officers and Members of the Faculty, and the Fee Table, 1848.*

Since we enjoyed reading these library privileges that existed very strict requirements for 124 years ago, we thought you might enjoy perusing them also. Particularly interesting is the fact that fines were determined by the size of the volume! Fines for pamphlets at 6¼ cents would now be an impossibility!

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## NEW ACCESSIONS – BOOKS
## (Arranged by Subjects)

### BACTERIOLOGY AND IMMUNOLOGY

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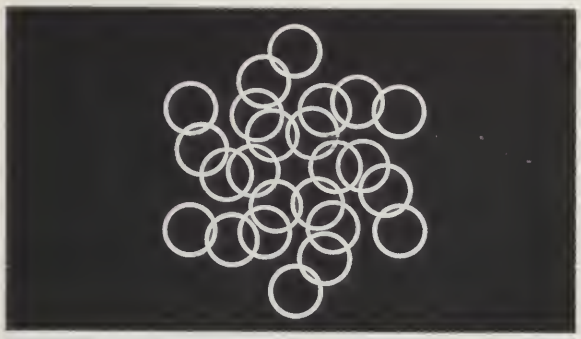
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland



# ALCOHOL-RELATED ILLNESSES

This is the first in a series of three articles originally published as Chapter Four of *Alcohol & Health,* an authoritative and up-to-date examination of the social and medical dimensions of alcoholism. You are urged to purchase this booklet from the Superintendent of Documents, US Government Printing Office, Washington DC 20402 — Price $1.50, Stock No. 1724-0193.

HEAVY DRINKING, ALCOHOL ABUSE, AND ALCOHOLISM have been implicated as primary or related causal factors in a large number of pathological conditions, although the exact frequency of most of these conditions is not known. For example, alcoholism is often associated with nutritional disorders, especially of vitamins such as folate, niacin, and thiamin. Deficiencies of these vitamins may be responsible for diseases of the neurological, digestive, and other body systems. Diseases of the heart and muscles, of the blood and other tissues, as well as mental disorders, are common in the course of prolonged alcohol abuse and alcoholism. Moreover, alcoholic persons whose alcohol dependency is not successfully treated are subject to an exceptionally high rate of morbidity and mortality. They more frequently fall victim to all sorts of illness not directly connected with alcoholism, and their lifespan is reduced by as much as ten to 12 years.

## Encephalopathies

Among the most serious diseases associated with alcoholism are the encephalopathies: Wernicke's syndrome, Korsakoff's psychosis, niacin-deficiency (Jolliffe's) encephalopathy, and Marchiafava's disease.

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The Wernicke's syndrome, characterized by clouding of consciousness and paralysis of eye nerves, is definitely associated with an acute severe deficiency of vitamin $B_1$, and responds well to prompt treatment with thiamin. Korsakoff's psychosis is characterized by disorientation, failure of memory, and a curious tendency to make up for the defect by substituting imagined occurrences. Because it is often, though not always, accompanied by peripheral neuropathy and sometimes follows on the symptoms of Wernicke's syndrome, thiamin deficiency has been suspected of being implicated in the causation of Korsakoff's psychosis. In patients who do not recover from the acute form of this mental disorder within weeks, it may continue as a chronic condition requiring prolonged hospitalization. Niacin-deficiency (Jolliffe's encephalopathy is marked by clouding of consciousness, cogwheel rigidities of the arms and legs, and uncontrollable sucking and grasping reflexes. It is due to an acute total deficiency of niacin, and responds to massive doses of this vitamin together with other elements of the vitamin B complex. It is fatal if treatment is delayed. Marchiafava's disease is a relatively uncommon degeneration of a specific part of the brain—the corpus callosum—causing several mental malfunction. Because the behavioral symptoms are not specific, the diagnosis is rarely made except at autopsy.

Many of the severe, chronic diseases closely associated with alcoholism result in serious damage to the brain, liver, and other vital tissues. Most of these progressive pathological changes are largely due to the nutritional defects which almost inevitably accompany chronic heavy alcohol consumption. Some recent evidence implicates alcohol more directly.

## Alcohol and the Liver

The liver is the organ which is most significantly involved with processing alcohol in the body and, at the same time, is most often seriously affected by heavy drinking and alcohol abuse.

### Alcohol Metabolism

Alcohol is primarily a foreign compound. It does not require digestion like other foods. It passes directly into the bloodstream and is distributed throughout the body by the circulating blood. A small portion is diffused into the blood directly through the stomach walls. The rest of the alcohol passes through the pylorus, the sphincter muscle separating the stomach from the intestines, and most of it is absorbed into the bloodstream through the walls of the small intestine. As the circulating alcohol—now enormously diluted in the body fluids—passes through the liver, it is subjected to the action of the enzyme ADH (alcohol dehydrogenase), as well as the coenzyme NAD (nicotinamide-adenine dinucleotide); this begins the process of metabolizing the alcohol by converting it to acetaldehyde. The latter, in turn, rapidly undergoes further metabolic change, producing acetate which is utilizable for energy and, finally, carbon dioxide and water. A small part (about 10% of the absorbed alcohol) is eliminated in an unmetabolized form through the kidneys, lungs, and sweat glands. The rest is oxidized mostly in the liver, since this organ contains the bulk of the necessary ADH.

This "organ specificity," plus the limited availability of NAD and the absence of a "feedback" mechanism that could adjust the rate of alcohol metabolism of the liver, probably explains why alcohol oxidation can produce striking imbalances in that organ. One of the effects of the metabolism of large amounts of alcohol is that blood lactic acid is increased. This slows the excretion of uric acid by the kidneys. Since high levels of uric acid in the blood are associated with gout, this may explain the common clinical observation that heavy consumption of alcoholic beverages is a frequent aggravating or precipitating factor in gouty attacks.

### Fat Metabolism

The process of alcohol oxidation releases excess hydrogen in the liver, an event which has a number of deleterious effects when very large amounts of alcohol are involved. The release of excess hydrogen is associated with an accumulation of increased fat in the liver. The increase in hydrogen also inhibits certain metabolic functions important in the production of energy from several sources (the citric acid cycle). Under these conditions, the mitochondria (particles in the cell responsible for the production of energy) will utilize the hydrogen from the alcohol rather than oxidize fatty acids. In other words, alcohol becomes the "preferred fuel" and, instead of burning fat, the liver burns alcohol. The decreased oxidation of fat results in the deposition in the liver of dietary fat, when available or, in its absence, increased fat in the liver is derived from adipose tissue and from new internal formation.

The liver can dispose of excess fat (lipids) by increasing its secretion of lipoproteins into the blood. This contributes to the mildly elevated fat content in the blood (hyperlipemia) which is commonly associated with chronic heavy drinking. When potentiated by diabetes, pancreatitis, or underlying abnormalities in lipid metabolism, the alcohol-induced hyperlipemia can be strikingly exaggerated. The eponym "Zieve's syndrome" is often used to characterize the simultaneous occurrence of fatty liver, hemolytic anemia, and jaundice in association with hyperlipemia. With severe liver disease, however, blood lipids may be normal or even subnormal. It has recently been found that the red blood cells in the capillaries of persons who have been drinking tend to clump together. The observation of this clumping phenomenon, which may result in sludging of blood cells, is currently under investigation.

### Fatty Liver

If alcohol abuse is gross and prolonged, the hyperlipemia mechanism is insufficient to prevent lipid accumulation in the liver, and extensive fatty liver will develop. This may be exacerbated through continuous damage to liver function.

The accumulation of fat is the initial lesion produced in the liver by heavy consumption of alcohol. The frequency of fatty liver in alcoholic persons was reported 120 years ago. This disorder has little accompanying inflammation and few functional consequences, although in some cases minor derangements have been reported. Cholestasis may develop. Rarely, an individual may develop jaundice and die in hepatic coma. Both moderate and massive fatty liver are usually entirely reversible when alcohol abuse is terminated.

### Alcoholic Hepatitis

After a variable period of alcohol abuse—usually years—alcoholic hepatitis may supervene. This inflammatory liver disorder may or may not be associated with fat or cirrhosis, but usually

there is fever, with an elevated white blood cell count, pain in the right upper abdominal quadrant, and jaundice. Frequently the clinical picture is similar to that produced by gallstones. The most characteristic feature seen under the microscope is the so-called alcoholic hyalin of Mallory, a form of cellular degeneration which, with few exceptions, is peculiar to alcoholic liver injury. Although alcoholic hepatitis usually subsides if drinking is stopped, it is a potentially lethal condition, and some patients may die in hepatic failure despite discontinuing alcohol intake. If alcohol consumption continues, the hepatitis often progresses to cirrhosis, but in some cases it may do so even if alcohol abuse ceases.

### Alcoholic Cirrhosis

The association of alcoholism and cirrhosis of the liver was noted long ago by the famous English clinician William Heberden. Some statistics of the present century indicate that liver cirrhosis is directly correlated with per capita consumption of alcohol. The incidence of alcoholic cirrhosis is increasing, and the extent of the problem can be inferred from statistics in New York City where cirrhosis of the liver, most of which is probably alcohol-related, ranks as the third leading cause of death between the ages of 25 and 65.

It has been estimated that about 10% of alcoholic persons develop cirrhosis, a disease characterized by diffuse scarring of the liver. This disabling and potentially fatal complication of alcoholism generally correlates with duration and amount of alcohol consumption, and according to Lieber and associates seems not to be related to the nutritional status of the individual. Excess deposition of iron in the liver occurs in some cases of alcoholic cirrhosis, which in turn may increase the rate of fiber deposition in the liver. If they continue heavy drinking, individuals with alcoholic cirrhosis often die of hemorrhage from portal hypertension or of hepatic failure. However, despite the fact that the basic distortion of the hepatic architecture is irreversible, the outlook is strikingly improved with complete cessation of alcohol intake. A risk which accompanies cirrhosis, more commonly in its late stage and regardless of its cause, is the development of cancer of the liver. This occurs even in alcoholic persons who have not consumed alcohol for many years.

Another complication of alcoholic liver injury, fraught with the danger of severe vascular disturbance, is central sclerosing hyalin necrosis. This involves scarring around small veins in the liver, resulting in their fibrosis, narrowing and occlusion of their channels, and eventual distortion of the liver tissue. This process may lead to hypertension of the veins feeding the liver, even in the absence of cirrhosis.

In summary, alcoholic liver disease is one of the most serious consequences of alcohol abuse. Its progressively serious manifestations take the form of fatty liver, alcoholic hepatitis, and cirrhosis.

### Etiology of Alcoholic Liver Injury

Ever since the observation that alcoholism is associated with liver disease it was generally assumed that the cause was a toxic effect of alcohol itself. Thus Heberden in 1802 wrote that "the most common cause (of 'scirrhous livers') is an intemperate use of spirituous liquors, which specifically hurt the liver." Despite F. B. Mallory's early attempts to incriminate other agents, such as copper, this view of alcohol as the toxic agent was widely held until the 1930s, when nutritional defects began to be suspected. In the 1940s, Best and his associates concluded, on the basis of experiments in rats, that "there is no more evidence of a specific toxic effect of pure ethyl alcohol on liver cells than there is for one due to sugar." In Best's studies, alcohol accounted for only about 18% of the calories in the diets of the animals. In more recent experiments, when alcohol was incorporated in totally liquid diets given to rats, the amount consumed was increased to constitute 36% of the daily calories. These studies demonstrated that heavy alcohol intake even without nutritional deficiency could produce fatty liver and changes in liver cells similar to those seen in alcoholic hepatitis. Liver injury by such amounts of alcohol was demonstrated in both alcoholic and nonalcoholic volunteers, even when a diet adequate or enriched with respect to protein and vitamins was being consumed. In fact, increases in liver fat and damage to liver cells were consistently produced after heavy alcohol ingestion for as little as two days. All the changes produced by alcohol in the volunteers were rapidly reversible as soon as alcohol was discontinued. Liver injury was produced also by amounts of alcohol that did not cause intoxication—the equivalent of between seven and 13 oz of whiskey within 24 hours—such as are commonly consumed by many so-called social drinkers. This is consistent with the pattern of many individuals who drink considerably in the course of their work and social relationships, but who are rarely drunk, and who are not considered to be alcoholic persons by their associates. Such individuals, if they consume sufficient alcoholic beverages, appear to increase their susceptibility to liver injury.

Although alcoholic fatty liver is not an inflammatory condition, and is distinguishable from alcoholic hepatitis by light-microscopy, the remarkable similarity of the electron-microscope features suggest that the former may be the precursor of the latter. The chain of events from fatty liver to alcoholic hepatitis and cirrhosis is still hypothetical, however, and has not yet been verified in laboratory animals. This may be due to the fact that even with improved feeding techniques, alcohol intake by the rat is still below that commonly associated with cirrhosis in man; alcoholic cirrhosis usually requires ten to 15 years of heavy drinking, a period that has not been reproduced experimentally. Though the deposition of excess fat in the liver almost invariably follows heavy alcohol intake, relatively few alcoholic persons develop cirrhosis. It is therefore thought that moderate or intermittent fatty liver probably does not lead to cirrhosis.

The determinants for the development of cirrhosis are still unclear. In addition to the amount and duration of alcohol consumption, other factors could modify the ultimate response of the liver to alcohol. These include contaminants and flavoring of alcoholic beverages, the pattern of alcohol intake, genetic and constitutional predisposition, and malnutrition or the imbalance between nutrition and alcohol intake.

### References

A complete listing of the 27 references used with this article may be secured from Mr. Ludwig L. Langford, Division of Alcoholism Control, 2305 N Charles St, Baltimore Md 21218, or from *Alcohol & Health*. Information and reprint requests should also be directed to Mr. Langford.


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## Cancer of Esophagus Treatment Discussed

Going all out for a cure is not the right approach to treating cancer of the esophagus, a team of cancer specialists at the University of Maryland has concluded. Treatment aimed primarily at curing, particularly by methods calling for a combination of preoperative irradiation and surgical removal of the tumor, results in many treatment complications and operative deaths, with only a discouragingly low ratio of survivals to compensate.

Taking a hard look at the record, not only at Maryland but throughout the country, the team decided in 1969 that many had been sacrificed to save a few. "We changed our philosophy and determined to make the patients' comfort and well-being our primary objective," said John Hankins, MD, one team member, in his report to the annual meeting of the Society of Thoracic Surgeons meeting in San Francisco recently. "We now try first of all to restore the patients' ability to swallow, and avoid the high risks of more aggressive treatment aimed primarily at a cure."

Not that hope of a cure has been abandoned, Dr. Hankins stressed. "Experience shows that even the less aggressive treatment produces some long term cures," he said. "But the big advantage of palliative treatment is that not only the ones who are cured but the many others whose tumors progress in spite of all possible treatment are kept comfortable for the remainder of their lives, whether this be months or many years."

Of the 21 patients treated palliatively since 1969, all eventually recovered the ability to swallow satisfactorily. There were no radiation-induced fistulae and no gastrostomies needed to be performed.

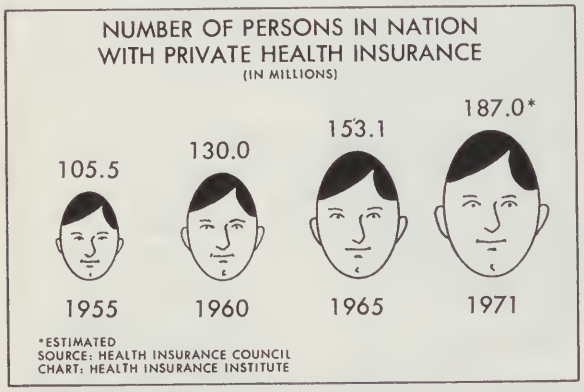
Even though treatment was not aimed at a cure, the mortality rate was lowered because no deaths occurred as a direct result of treatment. Eleven of the 21 treated palliatively are alive today, all with excellent swallowing. Eight died within ten months, but one lived 13 months and one, 27 months; all swallowed satisfactorily until the time of death.

This compares favorably with records of 234 patients (average age 60) treated by various methods at the University of Maryland Hospital between 1958 and 1969: only six lived five years or more; the others survived from two to 32 months. A review of 12,000 cases reported several years ago by William G. Plested MD, and colleagues at the Wadsworth Veterans Administration Hospital in Los Angeles led them to conclude that from 80% to 90% died within 12 months regardless of treatment.

Dr. Hankins' team found that cancer behaves differently and responds to treatment differently at different levels of the esophagus, and they designed treatment plans accordingly. In the cervical and upper third of the thoracic esophagus, supervoltage irradiation alone gives better results, they found, than surgery.

In the middle third of the esophagus, tumors are most frequent and also most resistant to treatment, partly because they are so close to the aorta and other vital structures. No preoperative irradiation is used here because it produces distressing complications. In both the middle and lower third of the esophagus, the Maryland team attempts to remove as much of the tumor as possible, with no strenuous effort to remove extensions. To restore swallowing, the stomach is brought up to replace the esophagus. Of 11 middle-third patients treated palliatively, six are alive at four to 17 months; five died at three to 13 months.

Most important, Dr. Hankins reported, "the quality of life for these 21 patients was improved immeasurably." Hospitalization time has been reduced also, and because the patients can swallow they are well nourished.




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## AMA to Cosponsor Israeli Medical Tour

The American Medical Association will cosponsor with the three principal medical institutions in Israel a 1973 medical conference in Tel Aviv.

Open only to AMA members, their families and guests, the 14-day trip, with 13 days in Israel, will include scientific presentations by leading Israeli authorities as well as visits to medical schools and other medical and research facilities.

Included will be several receptions, ceremonies, and a series of planned excursions to places such as Negev, Beersheba, Massada, Jerusalem, Bethlehem, Jericho, Galilee, Nazareth, Tiberias, Safed, Kibbutz, Nof Ginossar and, of course, Tel Aviv. There will be women's programs, including style shows, while the scientific meetings are in session.

The undertaking is a part of AMA's continued interest in the area of international health and marks the first attempt at cosponsoring a formal meeting abroad.

Albert B. Sabin, MD, of US polio vaccine fame and currently president of the Weizmann Institute of Science in Tel Aviv, is the guest host. Also participating in the scientific portion of the program are the Hebrew University - Hadassah Medical School of Jerusalem, and the Tel Aviv University Medical School.

Tour participants are scheduled to leave the United States Feb 21, 1973, arriving in Tel Aviv the following day. Departure from Israel will be March 6. Registration for AMA members is $50 and $25 for relatives and physician guests. This will include the scientific meetings, a concert by the Israel Philharmonic Orchestra, and other special features.

Each of the three local host institutions will arrange one day of scientific presentations for the participants.

The Weizmann Institute will offer presentations in the area of cancer research and special research being conducted which is of special medical significance.

Presentations on hypertension, treatment of mental diseases, heart disease, and progress in heart valve replacement will be given by the staff at Tel Aviv University Medical School.

Many of the socio-economics of Israel including medical care, medical education, manpower, community medicine, and Israel's contribution to International Health will be offered by the Hebrew University — Hadassah Medical School.

All of the scientific sessions will be at the Hilton Hotel in Tel Aviv.

Subscriptions to the tour will be limited by the availability of hotel space in Tel Aviv.

Group travel arrangements are being coordinated by the Sentinel Travel Bureau of Chicago. Round-trip fare New York to Israel and return will be $873 to $945, depending on hotel selection and the number of other stopovers in Europe. The package includes the various excursions scheduled in Israel and breakfast and dinner each day on the excursion. Group-fare reductions will also apply to tickets from home to New York and return. Special side tours can be arranged with the travel bureau for the time before or after the meetings in Israel.

Detailed program of the meetings in Israel can be obtained by writing to the Department of International Medicine, American Medical Association, 535 N Dearborn, Chicago Ill 60610.

Arrangements for special sight-seeing tours at group rates can be arranged directly with the Sentinel Travel Bureau, 400 E Randolph St, Chicago Ill 60601.

Requests for registration for the medical meeting in Israel should be addressed to the Department of International Medicine, American Medical Association, 535 N Dearborn, Chicago Ill 60610, and be accompanied by your registration fee remittance ($50 per physician and $25 per accompanying relative or guest). Such registrants will then be contacted directly by the Sentinel Travel Bureau for specific travel arrangements.

## Did You Know?

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- HMO medical services stress prevention of disease by providing regular check-ups, routine immunizations, prenatal care and early detection and treatment of illnesses.

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Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

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The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

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Aloha Carnival ..... 29

AMA Medicredit ..... 20

Arch Laboratories ..... 78

Arundel Fed. Savings & Loan Assoc. ..... 87

Baltimore Nurses Exchange ..... 94

Beecham-Massengill Pharm. ..... 82

Burroughs Welcome Co. ..... 21, 45

Capital Savings & Loan Association ..... 35

Oscar Caplan & Sons ..... 10

Connecticut Mutual Life Insurance Co. .... 88

Dow Pharmaceuticals ..... 2

Dulaney Towson Nursing & Convalescent Home ..... 35

Embassy Dairy ..... 31

Franklin Uniform Co. ..... 92

Geigy Pharmaceuticals ..... 1

Herget & Co. ..... 86

Eli Lilly & Co., Inc. ..... 48

Med-Chi Directory ..... 78

Med-Chi Retirement Plan ..... 93

Monarch Lincoln-Mercury ..... Cover 3

Pharmaceutical Mfrs. Assoc. ..... 79-81

Wm. P. Poythress Co., Inc. ..... 3

Public Service Vehicle Equipment Leasing ..... 13

Geo. Radebaugh & Sons ..... 13

Read's Drug Stores ..... 10

Roche Laboratories ..... Cover 4, 4-5

Manuel Schwartz Hearing Rehabilitation 86

G. D. Searle Co. ..... 42-43

Security Business Services, Inc. ..... 31

Smith, Kline & French Labs. ..... 44

Special Diet Shop ..... 25

Sterling Lighting Co. ..... 35

Stuart Pharmaceuticals ..... 41, 46, 47

Therapeutic Appliances ..... 10

Tio Pepe Restaurant ..... 87

Towson Surgical Supply ..... 10

Upjohn Co. ..... 22-24

D. Stuart Webb Advertising Services, Inc. .. 31

White Rice Inn ..... 87

Vera Woods Personnel Service ..... 25

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VOLUME 21 AUGUST 1972 NUMBER 8


**COVER:**

The hospital series is interrupted this month to again picture the Faculty Building on the front cover of the Transactions Issue. This handsome building at 1211 Cathedral St in the Mt. Royal section of Baltimore has housed the headquarters of the Medical and Chirurgical Faculty of Maryland since May 13, 1909. The Faculty has had several Baltimore locations since receiving its charter in January 1799 and was located at 847 N Eutaw St prior to moving to the present home.

**EDITORIAL:**


**The AMA and You**—Robert vL. Campbell, MD ..... 8

**ANNUAL REPORTS:** ..... 49-90

**Index** ..... 49


**DEPARTMENTS:**


**Your Medical Faculty at Work**—John Sargeant ..... 6

**Woman's Auxiliary—Mrs. Kolkin's Inaugural Address** ..... 14

**Maryland Medical Political Action Committee** ..... 17

**Peer Review Committee** ..... 40

**Library—SLA Boston 1972; New Accessions** ..... 101



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**MISCELLANY:**


Doctors Take Note **3**

Director's Newsletter **11**

Doctors in the News **15**

New Council Members **16**

Semiannual Meeting **18, 107**

Medical News Briefs **26**

Minutes of the House of Delegates Meeting **32**

Book Reviews **37**

AAMA **40**

Component Societies **94**

Classified Advertising **107**

Advertising Index **108**



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*Contraindications:* Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
*Warnings:* Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
*Precautions:* The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
*Adverse Reactions:* This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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# Doctors take note...

## MARYLAND AREA MEETINGS

| | | |
|---|---|---|
| Sep | 14-16 | **Med-Chi Semianl Mtg,** Ocean City Md. See program elsewhere in this issue. |
| Oct | 6 | **Children's Med & Surg Cen, Johns Hopkins Univ,** Baltimore. Progress in Pediatrics 1972. Clinical program & PM banquet. Contact: Matthew Debuskey MD, CMSC 2-124, Johns Hopkins Hosp, Baltimore Md 21205. |

## OBSTETRICS & GYNECOLOGY

| | | |
|---|---|---|
| Oct | 12-14 | **Fourth Anl Postgrad Crs in Current Concepts in OB-GYN,** New York City. Contact: Registrar, Page & Wm Black Postgrad School of Med, Mount Sinai Sch of Med, Fifth Ave & 100th St, New York NY 10029. |
| Oct | 23-27 | **Clinical & Histopathological Survey of OB-GYN, Livingston NJ.** Contact: JL Breen, Dept of OB-GYN, St. Barnabas Med Cen, 94 Old Short Hills Rd, Livingston NJ 07039. |

## MISCELLANEOUS MEETINGS

| | | |
|---|---|---|
| Sep | 10-16 | **American Society for Gastrointestinal Endoscopy,** postgrad clinical gastroenterology crs, Castle Harbour Hotel, Bermuda. Contact: VM Smith MD, 301 St. Paul Place, Baltimore Md 21202. |
| Sep | 11-13 | **Problem-Oriented System Symposium,** Atlanta. Designed for med educ directors & other key hospital staff mbrs assoc with patient care, records & med educ. Sponsor: Dept of Med, Emory Univ Sch of Med. Contact: AN Nelson, Dept of Med, Emory Univ, 69 Butler St SE, Atlanta Ga 30303. |
| Sep | 19-22 | **American Rhinologic Society,** New Orleans. 18th anl mtg 22. Resp phy, rhinomanometry, corrective nasal surg workshops & seminars 19-21 cosponsored by La State Univ Sch of Med. Contact: GF Joseph MD, 3622 Government St, Baton Rouge, La 70806. |
| Oct | 2-3 | **Air Pollution Med Research Conf,** Chicago. Sponsor: AMA. Contact: Dept of Environmental Public & Occupational Health, AMA, 535 N Dearborn St, Chicago Ill 60610. |
| Oct | 12-14 | **American Electroencephalographic Society,** anl mtg, Houston. Contact: Mrs. Margaret Henry, American EEG Society, 36391 Maple Grove Rd, Willoughby Hills, Ohio 44094. |
| Oct | 23-24 | **Environment & the Skin Symposium,** Cincinnati. Sponsor: AMA Comm on Cutaneous Health & Cosmetics. Contact: Comm on Cutaneous Health & Cosmetics, AMA, 535 N Dearborn St, Chicago Ill 60610. |
| Oct | 27-28 | **Peripheral Arterial Symposium,** Philadelphia. Sponsor: Temple Univ Hosp. Contact: Dept of Rehab Med, Temple Univ Health Sciences Cen, 3400 N Broad St, Philadelphia Pa 19140. |
| Nov | 24-25 | **Conf on Radiology in Otolaryngology & Ophthalmology,** Chicago. Sponsor: Abraham Lincoln Sch of Med, Univ of Illinois Med Cen. Contact: GE Valvassori MD, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680. |

## AMERICAN COLLEGE OF PHYSICIANS

(Info on all crs, contact: ACP, 4200 Pine St, Philadelphia, Pa 19104.)

| | | |
|---|---|---|
| Sep | 25-29 | **Basic Mechanisms in Internal Medicine,** Medical College of Va, Richmond. |
| Oct | 2-4 | **Current Concepts in Hematology,** Univ of Pittsburgh Sch of Med, Pittsburgh. |
| Oct | 2-4 | **Developmental Biology & Perinatal Med,** McGill Univ, Faculty of Med, Montreal. |
| Oct | 2-6 | **Nonmedical Use of Drugs: Challenge to the Physician,** New Jersey Col of Med, Newark. |
| Oct | 9-11 | **Advances in Therapeutics & Clinical Pharmacology,** Univ of Florida, Gainesville. |



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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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## To help you manage excessive psychic tension

# your medical faculty at work

**by John Sargeant, Executive Director**

**The Council met on Thursday, June 8, 1972, and took the following actions:**

1. Approved a recommendation to the House of Delegates for Emeritus Membership, at the request of a component society.
2. Accepted a report of its representative to the Tuberculin Testing and Evaluation Committee.
3. Approved recommendations from the Continuing Medical Education Committee a) endorsing a proposed certificate of accreditation which will be issued to approved institutions that receive educational accreditation and b) to discontinue operation of the MEDIC network, effective June 30, 1972.
4. Approved the location of the 1973 semiannual meeting for scientific sessions as Mexico City; designated the use of two smaller capacity jet planes rather than a 747 jet for transportation; and designated Travel Guide Agency as the travel agency to be used for this trip.
5. Referred to the Subcommittee on Child Welfare the policy adopted by the Faculty in 1967, dealing with services rendered under the Crippled Children's Program.
6. Authorized the Faculty president and delegates to the AMA to speak on behalf of the Faculty at the open hearing on Long Range Planning and Development scheduled by the AMA at its San Francisco meeting.
7. Approved proposed regulations, as amended, recommended by the Subcommittee on Immunization Practices for a) immunizations required prior to entering a Maryland school and b) immunization against smallpox of persons at high risk.
8. Designated D. Frank Kaltreider, MD, as Faculty representative to the Advisory Committee on Single Parent Services to the State Department of Employment and Social Services.
9. Received a letter of appreciation for Faculty endeavors dealing with the establishment of the Division of Family Practice, University of Maryland School of Medicine, from J. Roy Guyther, MD.
10. Referred to the newly established Committee on Joint Practices, House Bill 573 (Drug Substitution bill) for study with interested parties involved and any recommendations it may have for proposed legislative changes.
11. Appropriated $1,000 from the Educational Fund to the MMPAC for educational activity.
12. Deferred action on a request from the Committee on Preventive Medicine and Public Health that Blue Cross be urged to increase coverage for normal pregnancies to ten days hospitalization; and to provide abortion benefits for single as well as married subscribers.
13. Approved submission of a list of nominees to the AMA for consideration for appointment to various AMA Boards and Councils.
14. Declined to support a proposed resolution that would have given authority to the various statewide specialty groups to commit the Faculty to policies as determined by such statewide specialty groups when no existing Faculty policy was in effect. This dealt with legislative matters before various government agencies, departments, and the General Assembly.

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**The Executive Committee met on Thursday, June 1, 1972, and took the following actions:**

1. Authorized the seeking of a consultant on pension programs for the purpose of evaluating the Faculty employees' pension plan to ensure it is appropriate for the funds expended.
2. Adopted two position statements as recommended by the Nursing Liaison Subcommittee involving:
   a) The extended role of the professional nurse, and
   b) Vaginal inspection to perform IUD string checks and to collect specimens for PAP smears and cultures for laboratory tests.
3. Tabled a request from the University of Maryland School of Medicine asking for comments on the proposed Physician Assistant course at this institution. This was done because the Board of State Colleges has declared a moratorium on all new health manpower courses until completion of a study by a special task force of the Advisory Council on Higher Education.
4. Studied a summary of the recommendations of the State Department of Health and Mental Hygiene in connection with its investigation of the Carroll Hall Nursing Home. Agreed to write the Department advising it that a position paper had already been adopted by the Faculty in

connection with the duties of a Medical Director or Principal Nursing Home Physician; and to concur in a proposal that exceptions be made to the current law dealing with transportation of bodies over state lines without a death certificate. Such exceptions would apply to borderline states only.

5. Authorized the establishment of an instructional class in parliamentary procedure to be held in conjunction with the Ocean City meeting. It would be scheduled for 8:30 AM to 9:30 AM immediately preceding the House of Delegates session on Friday, Sept 15, 1972. A continental breakfast of juice, coffee, and rolls would be provided at 7:45 AM for all attendees. The class would be open to House of Delegates members, Faculty members, and Woman's Auxiliary members.
6. Authorized the executive director to contact the secretary of the Department of Health and Mental Hygiene to reaffirm its previous offer of assistance in any way possible in connection with a task force named to examine the Medicaid program in Maryland. It also authorized the executive director to make contact with other government officials in both executive and legislative branches to make known the Faculty's positions in this regard.
7. Adopted the following resolutions in connection with minimum qualifications of X-ray technologists:

   *Resolved,* That the Medical and Chirurgical Faculty endorses the principle that X-ray exposure in medical practice should be maintained as small as possible consistent with the acquisition of the desired clinical information;

   *Resolved,* That the Faculty will encourage its members to train their technologists in the fundamentals of radiologic techniques and will encourage schools and hospitals to maintain the highest standards of training; and

   *Resolved,* That the Medical-legal Committee explore ways to reduce the number of films taken strictly for legal rather than for medical reasons.
8. Appointed the executive director to represent the Faculty on the Maryland Health Data Committee.
9. Referred to the Public Relations Committee a pamphlet issued by the Illinois State Medical Society outlining services not covered by Medicare. This committee will evaluate and report comments or recommendations in this regard.
10. Took no action on a voluminous document received from the AMA, including the President's message to Congress on the Administration plans for older Americans.
11. Declined to adopt a resolution suggested by the California Medical Association opposing the shift in emphasis of Regional Medical Programs to delivery systems of health care.
12. Learned that John T. Chissell, MD, Baltimore, is a member of the Comprehensive Health Planning Agency task force to "develop a plan of definitions, recommendations, and guidelines for the development of Ambulatory Care Facilities."
13. Accepted a proposed budget for the Maryland Foundation for Health Care for the purpose of approaching third-party carriers for financial support of the Foundation. The treasurer will use this in his discussion with such third parties.
14. Approved solicitation on a local level of non-AMA members, with the AMA underwriting the costs in this connection.
15. Agreed to support the reappointment of Ramsey B. Thomas, MD, Baltimore, to the State Board of Education.
16. Approved a change in the cancellation clause of the St. Paul Companies' Professional Liability policy from 30 days to 45 days. This is in accordance with state law, and has been approved by legal counsel.
17. Declined to take action at this time in connection with a contribution of funds to assist in erecting a plaque on the site of the former home of William S. Halstead, MD, until such time as it knew what other groups were doing in this connection.
18. Approved a Hypertension Detection and Follow-up Program being conducted by the Department of Preventive Medicine, University of Maryland School of Medicine, for patients in the census tracts around University and Provident hospitals. The Baltimore City Medical Society has already given its approval in this connection.
19. Agreed to recommend appointment to the Medical Advisory Board, Department of Motor Vehicles, of the following physicians:

    Sarah Tenenblatt, MD, Psychiatrist, Silver Spring; and
    Frederick S. Caldwell, MD, Internist, Rockville.

# Editorial

# THE AMA AND YOU

**ROBERT vL. CAMPBELL, MD**
**Senior Delegate (Maryland)**
**American Medical Association**
**House of Delegates**

If there is one thing I can say without fear of contradiction, it is this: there is no one thing doctors will ever agree on 100%.

The point I make is that it is obvious that neither the AMA nor any organization can represent all of the doctors all of the time. There is just too much diversity of view. You have your personal, political, and philosophical views. I have mine. Other doctors have theirs. And this diversity is intensified by a characteristic I think we all share—that of being strong individualists.

How then, in a profession as large and as diverse as ours, are we to determine what the organization that represents medicine should be?

If we are to have a professional organization at all; if it is to be a viable, functioning organization; we must find some common ground, some common cause. We must arrive at a consensus—basic agreement by the majority—if we are to establish the purpose of our organization and its guiding principles.

What part can you play in the determination of these principles, these courses of action? That's entirely up to you. If you want to be part of the action, you can be. It may surprise you, but the avenues are there; and they are wide open for anyone who chooses to use them.

To begin with, you have a say in the election of your state delegates. They in turn have a say in who's going to represent your views in the AMA House of Delegates—the national policy-making body.

In a very real sense you, by electing your representatives, influence AMA policy.

There's another avenue: one that's your democratic right, as well as responsibility, to use. You can press your views on your state and national delegates. Go see them. Phone them. Write them. Let them know what you don't like, what you want to see changed. By the same token, if you agree, let them know they've got your support.

There's one further avenue. You can go right to the top, and express your views before the AMA House Reference Committee at either of the two annual conventions.

Today there are several areas in particular where our rights and interests need strong and dedicated representation. One is government.

In all of its relations with government, the AMA has established one underlying principle or position: The private sector can most effectively and efficiently bring about the improvement in health care services. Where the private sector's resources are insufficient, government funds must be secured. But government should not be permitted to dictate the terms of medical practice or education.

Right here, I think, is a good place to stress one very important point. Earlier I made reference to the fact that doctors are, by nature, strong individualists. But in one sense, individualism has a serious drawback. Alone, you or I can do little or nothing to influence issues on the national level. Together, we can do much. That is why we must have a strong national spokesman.

Then there's the issue of manpower, or, as some are wont to call it, the "doctor shortage." And who's blamed for it? The AMA. While the AMA did at one point underestimate the demand for physician services in the future, it didn't hesitate to reverse itself once it realized the mistake.

Since 1963, the AMA has been in the forefront in supporting legislation to increase the number of medical schools, and the number of doctors and allied health personnel. Most of this legislation has since been passed.

But note this well. While helping to secure

those federal funds, the AMA was instrumental in keeping the government from dictating the terms.

There are other areas of responsibility the AMA has staked out for itself. One is that of standard-bearer for the quality of medicine.

And I think all of us are well aware of its guiding principles. As monitor of educational standards, guardian of professional ethics, publisher of scientific information, and in many other ways, the AMA has exerted a major influence in creating the environment and providing the tools for medical quality and progress.

Think back to when we emerged from medical school. We came out with what is the best educational opportunity anyone ever had. The same can be said for the intern and residency training we received. I think it proper to remind you that the high educational standards we all benefited from were high because of what our predecessors in medicine insisted upon through the AMA. The board certification we have has meaning because of what physicians did through their organizations, including the AMA. I happen to believe we all still have an obligation to the men and women who are following us into medicine. We have to pass on the same high standards for them; and the only way I know to insure that is through our support of the AMA.

Think of the other ways the AMA helps maintain quality. It shares in the responsibility for the accreditation of the hospitals you depend on for the care of your patients. It certifies the schools and the training programs for the nurses and technicians you depend on in your everyday practice.

It is the AMA that sets the standard for the code of professional ethics. While it is ultimately you who must be the guardian of these ethics, it has been the AMA that has been responsible for establishing the guidelines.

Who keeps you abreast of the scientific explosion? Through its journals and other publications, special committees and councils, conventions and study sessions, the AMA provides you with a constant flow of information—information which is vital to your practice.

What does the AMA do for you as an individual? There are a number of very practical things. One is insurance. The AMA offers a wide range of programs especially designed for physicians, with the added benefit of group rates.

As you're well aware, the everyday business of managing your practice is growing more and more complex. The AMA can help by providing the information you need such as information on setting up a practice, billing and collecting, and financing; in fact, information on just about every aspect of running your practice.

And finally, the AMA has assumed leadership in the area of socio-economics.

There are those who accuse the AMA of not doing enough, of not being sufficiently active in finding solutions to this aspect of health care.

Let me assure you that the AMA is acutely aware of the pressing need for new, improved, and expanded health care services. Inherent in providing them is the need to find solutions to a vast array of social, economic, and legislative problems.

The AMA doesn't have all the answers.

But it *does* have a very definite and clear position. It has pledged itself to an expanding role in the planning and developing of health and medical care programs in all their ramifications.

You're well aware of the chronic shortage of doctors in our slum and rural areas. To provide more and better medical care in those areas, the AMA is pursuing a number of approaches: contracts for future service tied to scholarships or loans, new technology in bio-medical monitoring, more imaginative use of transportation like helicopters, and wider use of allied health personnel.

The AMA is also working closely with the National Health Service Corps in its efforts to get more doctors into under-serviced areas.

I started off by saying there is no one thing doctors will ever agree on in total. It is important that we do not. Difference of opinion is the catalyst of change.

But I submit that upon thoughtful consideration you and I and most doctors can find common cause with the AMA's purpose, goals, and, hopefully, a majority of its guiding principles.

There will always be areas of disagreement. No human organization can be totally representative. But it's important for you to know that the AMA has entered a period of self-examination and change, change that will be directed only by those of you interested enough and dedicated enough to be a force in that change.



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# executive director's newsletter

August 1972

**CAUTION TO ALL PHYSICIANS**

Whether physicians are more gullible than others in responding to solicitation letters, we are not sure. However, repeated mailings for listings in various "directories" result in making payments for such listings without thinking about them.

Many times, these invoices appear in the form of yellow page bills, confusing the issue more than ever.

On other occasions, physicians are solicited for group travel arrangements by what appears to be reputable organizations. Implications are that "special arrangements" have been made for "Maryland physicians." Indirectly, on casual reading, it appears as though these plans are sponsored by the medical society.

Caution is urged by all those who are interested to ensure that courses or travel plans are indeed Faculty sponsored or are operated by reputable organizations.

**DRUG SUBSTITUTE BILL**

The Drug Substitution bill, HB 573, signed into law by the Governor does not take effect until Dec 1, 1972. In any event, the present situation is a) the pharmacist must notify the physician of any substitution made within 24 hours and in writing, b) the drug substitution made is from the Medical Assistance Program "Formulary" -- which does not exist, and c) the physician can indicate "No Substitution."

Further developments will be communicated to all physicians when they occur.

**ANNUAL REPORTS**

Appearing in this issue of the Journal are the annual reports of Faculty committees.

Delegates and others are reminded that these are not being reprinted and this issue of the Journal should be saved for use at the semiannual House of Delegates session.

**INFORMATION SOUGHT**

Physicians in the greater Baltimore area are alerted to a man by the name of W. Paul Kitonis, III, who is seeking employment as a "Physician Assistant."

Should he present himself, please let either Mr. Charles Tregoe, Chief, Div. of Drug Control, State Dept. of Health & Mental Hygiene (383-2730) or the Faculty office know.

TRAVEL PLANS

Travel plans available to Faculty members and relatives include the following:

Nov 3, 1972 - 8 days Hawaii, $399, plus tax, all inclusive (hotel, transportation, two meals a day).

May 31, 1973 - 14 days Scandinavian Countries (Denmark, Sweden, and Finland, with side trip to Leningrad) $798 plus departure taxes, for transportation, hotel, and two meals per day.

Sept 19-23, 1973 - 5 days Mexico City, as part of the Semiannual Meeting, $286, all inclusive (hotel, transportation, two meals a day).

Details in the mail shortly; or contact can be made with the Faculty office for further information.

INFORMED CONSENT

Consent forms developed by a special committee of the Faculty in cooperation with legal counsel have recently been reviewed and found to be still current in their applicability.

Sets of the informed consent forms, in accordance with Maryland statutes, are available on request from the Faculty office.

AMA-ERF CONTRIBUTIONS

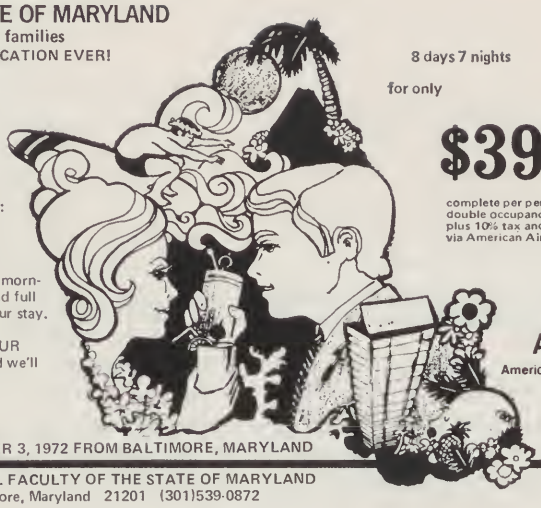
At the recent AMA meeting, a resolution was adopted that will require a brief report on the expenditure of AMA-ERF funds from those medical schools receiving contributions from this source.

The latest communications from Hopkins and University indicate that funds received in 1972 are to be used for the development of new educational programs and to upgrade the quality of existing programs.

John Sargeant
Executive Director

# Aloha Carnival

for members of
THE MEDICAL & CHIRURGICAL
FACULTY OF THE STATE OF MARYLAND
and their immediate families
GREATEST HAWAIIAN VACATION EVER!



8 days 7 nights
for only
**$399**
complete per person
double occupancy
plus 10% tax and services
via American Airlines

AA AmericanAirlines

We won't presume to improve Hawaii . . . nature has done an excellent job of that already. But we HAVE added a silver lining to an already luxurious vacation package. Here is what the Aloha Carnival includes:

**DELUXE ACCOMMODATIONS**

at Hawaii's newest and most luxurious ocean-front resort . . . The Hawaiian Regent at Waikiki. Carnival vacations have always used the finest hotels in the world, but now we've gone a step further with our OWN Hawaiian Regent, a hotel unprecedented in its luxury and services, including several restaurants, clubs, shops, pool and top-name entertainment. And because the hotel is our own, our experienced Carnival staff can give you all the personal attention you deserve!

**FOOD FIT FOR A KING**

including champagne breakfast every morning and get-together cocktail party and full course dinner each evening during your stay.

If the Aloha Carnival sounds like YOUR way to travel, mail us the coupon and we'll send you more reasons to think so!

No other trip includes so much!

CHAMPAGNE BREAKFAST EVERY MORNING
FESTIVE COCKTAIL PARTY EVERY EVENING
GOURMET DINNER NIGHTLY
LUXURY ACCOMMODATIONS AT HAWAII'S NEWEST AND MOST LAVISH HOTEL

PLUS

- Round trip via American Airlines with food and beverages served aloft
- Free champagne in-flight
- Free in-flight movies
- Traditional flower lei greeting
- Half-day sightseeing tour of Honolulu
- Optional sightseeing tours at low Carnival prices
- Carnival Hospitality Desk in hotel lobby
- Host Escort throughout
- All transfers of you and luggage
- Pre-registration at hotel
- Briefing on highlights of Hawaii
- Plenty of attention but no regimentation

DEPARTING ON NOVEMBER 3, 1972 FROM BALTIMORE, MARYLAND

MEDICAL & CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
1211 Cathedral Street/Baltimore, Maryland 21201 (301)539-0872

Gentlemen:

Enclosed please find $_____ as deposit ☐ as payment in full ☐ for _____ number of persons.

Make check or money order payable to: ALOHA CARNIVAL

$438.90 per person double occupancy
$100 minimum deposit per person. Final payment due 35 days before departure. Please print and if more than one couple, attach a separate list with complete information as below.

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STREET _____ PHONE _____

CITY _____ STATE _____ ZIP _____

DEPARTURE DATE _____ DEPARTURE CITY _____

☐ Single occupancy (if individual, and not a single, name of person sharing room) _____

Return this reservation immediately to assure space. Rates based on double occupancy. Single rates $75 additional. Rates on children under 12 sharing room with parents $50 less. Although flights are usually non-stop, it may be necessary to schedule one stop enroute. Tour prices are based on rates and tariffs in effect as of the date printed herein, AITS reserves the right to adjust tour prices in the event of rate and tariff changes over which it has no control.

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals

★ One story new fire-safe construction.

★ Inspection invited. Reasonable rates.

★ All facilities available to private physicians.

## Where your convalescent Elderly, Bedfast or Disabled

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★ Professional Total Care Program.

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# INAUGURAL ADDRESS BY MRS. MARVIN L. KOLKIN

As your new president, it gives me special pleasure to add my own words of welcome to you this morning (May 4, 1972). I should like to preface my remarks by reminding you that our very name, Auxiliary, clearly denotes our purpose. By definition, an auxiliary is a helping assistant, giving support. The verb, auxiliate, means "to help."

As the wives of doctors who are dedicated to the medical care of their patients, we are in a privileged position to serve. As Auxiliary members, our concern and dedication can easily be transformed into deeds that reflect our interest and our concern for the health of all people in our community. The combined efforts of the doctor caring for his patients and the efforts of his wife, giving of herself through her volunteer work in her community, cannot help but make for a superb team dedicated to the improvement of the quality of life for all peoples.

I would urge you to go to your local medical society to tell them that you are available to help, in any way they wish, to assist in implementing their programs in your community. For example, perhaps there is a deficiency in your local public schools in the area of proper health education for youngsters and their parents alike, a deficiency which the combined efforts of the local medical society and its auxiliary can help erase. Or maybe your auxiliary can provide volunteer help in a Mobile Health Care Unit in one of your underprivileged areas. Or maybe your husbands want your help in mobilizing local political action committees in this election year which is going to be so crucial to the future of medicine. Or perhaps your medical society would welcome your assistance as hostesses at a local medical symposium. Let your medical society know you are available and willing to help them.

You also have available to you the vast program and educational resources of the AMA and the WA-AMA to make use of as you see fit. It it up to you, and you alone, to determine the areas of concern in your county to which you want to address your efforts.

We are planning, on the state level, to reorganize some of our committees to more closely correspond to the regional and national committees. We hope, in this way, to insure that the widest possible lines of communication are open and that the vast resources available to you can be properly distributed and utilized. We would suggest, therefore, that each county auxiliary decide for itself what areas of concern in their community properly need their attention and then concentrate on forming and building up those appropriate committees.

A small auxiliary may only have enough woman-power to concentrate on working with one or two committees. Carroll County, for example, with only 13 members, recognized a deficiency in the drug education their youngsters were receiving in their public schools. They arranged to obtain, on loan from the AMA Film Library, a superb film called "Drugs Are Like That," geared for showing to 3rd and 4th graders — an age group which is largely without suitable instruction in this terribly vital field. The Carroll County Auxiliary members will be showing this film for an entire week later this month.

Our larger auxiliaries have at their disposal, of course, far more woman-power and can successfully manage many more ongoing, active committees. There need be no reason for the concerned, active doctor's wife in your community to seek fulfillment outside of your auxiliary. If you are engaged in important, relevant work, she will want to be one of you. If you do not offer the means for that fulfillment, she will look to expend her energies by working for and with other groups in the community. And in these times of public rumblings, what better service can we Auxiliary members provide than to improve the public image of the physicians of our nation, while at the same time we work for the better health of all of our citizens. I urge you to assess the needs in your community and decide where your efforts would best be placed.

# Doctors in the News



Dr. Nelson

**Russell A. Nelson,** MD, chief executive officer of the Johns Hopkins Hospital since 1952, has asked that he be relieved of his executive duties as of June 30, 1973.

In making his request to the Trustees, Dr. Nelson said: "This month (June) I complete 35 years of full-time association with Hopkins as a member of the professional or administrative staff and 20 years as the chief executive officer of the hospital.

"Next year I will be 60 years of age, and with retirement only a few years away, I have come to a personal decision that while still in good health and strength, I would like to lighten my day-to-day activities.

"This would allow me to devote the remaining years of my professional career to those particular challenges of health services planning, organization, and development which have always intrigued me, but which I have never been able to assume full time."

"Dr. Nelson has had a distinguished career in medicine and hospital administration, for which he has received national and international recognition," said William E. McGuirk, Jr., chairman of the hospital's Board, in reluctantly acceding to his request.

Dr. Nelson came to Hopkins as a medical student and received his medical degree in 1937. Since then, his entire professional life has been spent there as a member of the staff, faculty, or administration.

•

**Harry C. Butler,** MD, was feted recently by some 200 friends with a 70th birthday dinner and retirement party at Rosewood State Hospital.

The event also marked the end of 40 years of service for the man who has been chief of somatic medicine at Rosewood for many years.

Greetings were read from Governor Mandel, who sent a certificate naming Dr. Butler "a distinguished citizen of Maryland."

Included in the shower of gifts was that of the governor's gold watch, said to be the last ever to be awarded to a 40-year state employee.

•

A Maryland doctor, **John W. Winkler, Jr.,** MD, Hyattsville, has been granted Fellowship in the American College of Cardiology (ACC), the national medical society for specialists in cardiovascular disease. He is among a group of 193 from the United States and Canada recently admitted to their highest membership classification.

•

New officers of the Maryland Industrial Medical Association, elected at the May 31 meeting, are: president, **Richard J. Phillips,** MD; president-elect, **John R. Davis,** MD, vice president, **Joseph J. Goldstein,** MD; and secretary-treasurer, **Henry L. Wollenweber,** MD.

•

**John D. White,** MD, Frederick, has been installed as president-elect of the Maryland Tuberculosis and Respiratory Disease Association.

Other Maryland doctors who will serve one-year terms with the group include **Aaron Traum,** MD, Silver Spring, immediate past president; **Allan S. Moodie,** MD; **Jason Geiger,** MD; and **John H. Janney,** MD; directors.

•

**Sylvan Frieman,** MD, a Baltimore County practicing physician with an extensive professional history in medicine, has been appointed to a three-year term on the Baltimore County Commission on Hospitals.

Formed in 1969, the commission works in close cooperation with the Baltimore County Health Department. The two agencies are currently engaged in a joint effort to combat the drug problem.

•

At the annual meeting of the Arthritis Foundation in Baltimore on June 2, **L. Myrton Gaines, Jr.,** MD, and **Harry F. Klinefelter,** MD, were elected vice presidents.

At the close of the meeting, awards of appreciation and distinguished service were presented to **Alexander S. Townes,** MD, and Dr. Gaines.

•

At the recent annual meeting of the Maryland Academy of Family Physicians, **Daniel I. Welliver,** MD, professor of family practice at the University of Maryland School of Medicine, was elected president.

Chosen as president-elect was **J. Richard Lilly,** MD, also assistant professor in the university's family practice program.

Others elected to office were **Howard N. Weeks,** MD, Hagerstown, secretary; and **J. Nelson McKay,** MD, Catonsville, treasurer.

Named vice presidents were **Hans Kotter,** MD, Baltimore, Central District; **Philip Heuman,** MD, Bel Air, Eastern District; **John Umhau,** MD, Chevy Chase, Southern District; and **Frank Thomas,** MD, Hancock, Western District.

Directors elected included **Theodore Patterson,** MD, Dundalk, Central District; **Earl Beardsley,** MD, Salisbury, Eastern District; **Richard Bauer,** MD, Adelphi, Southern District; and **Philip Mercer,** MD, Westminster, Western District.

**Archie Cohen,** MD, Clear Spring, was chosen as delegate to the American Academy of Physicians with Dr. Howard Weeks as alternate.

●

**Mark E. Gann,** MD, has been appointed surgeon-in-chief at Baltimore's Sinai Hospital. Dr. Gann, who will continue in private practice, follows **Arnold M. Seligman,** MD, who has been appointed chief of the department of research oncology and cell biology.

A native Baltimorean, Dr. Gann is a graduate of the Johns Hopkins University and medical school.

●

## MEET YOUR NEW COUNCIL MEMBERS

In order that Faculty members may become better acquainted with their elected leaders, photos and short biographies of each will be published in the *Maryland State Medical Journal.*

The series begins with **William Carl Ebeling,** MD, who will serve as president-elect for 1972-1973 and become president in the 1973-1974 Faculty year.

No stranger to Med-Chi affairs, Dr. Ebeling served as Faculty secretary, 1961-1963; and as a councilor, 1964-1970.

He also serves the Faculty as a 1969-1974 alternate delegate to the AMA, and is a 1968-1972 member of the Blue Shield Board of Trustees.

He first saw the light of day 50 years ago in Washington, DC.

His premedical education was secured at the University of Maryland, where he received his BS in 1943. His MD followed there in 1944.

The University of Maryland Hospital numbered him as a rotating intern in 1944-1945 and as an assistant resident in medicine in 1945-1946 and 1948-1949. He took time out in 1946-1948 to serve with the US Army.

Leaving the Free State in 1949, he became assistant resident in pathology at Vanderbilt University Hospital from where he returned to Baltimore in 1950 as resident in medicine at the University of Maryland Hospital

He again departed Maryland in 1951 to become fellow in medicine at the Massachusetts General Hospital and a postgraduate assistant in endoscopy in 1952.



**Dr. Ebeling**

He returned to our midst in 1952 as assistant professor of medicine at the University of Maryland School of Medicine and continues in that assignment.

Dr. Ebeling, who is chief of medicine at St. Joseph Hospital, is also on the staff of the University of Maryland Hospital.

In addition to Med-Chi membership, he also belongs to the Baltimore County Medical Association, the American Medical Association, and the American Society of Internal Medicine.

He is a Fellow in the American College of Physicians and was certified in 1955 by the American Board of Internal Medicine.

His office is located at 7401 Osler Drive in Towson. He and his wife, the former Celeste Capone, have four children and reside in the Ruxton section of Baltimore County.

Let's all welcome Dr. Ebeling to his new Faculty duties and pledge him our full cooperation!

Maryland Medical Political Action Committee

**RAYMOND L. MARKLEY, MD, Chairman**

**MRS. FRANCIS C. MAYLE, Editor**

# MMPAC MEMBERSHIP AFFECTS LEGISLATION

Your MMPAC membership may not seem to you to have a very direct effect on legislation. To help you understand how the process works consider the following diagram.

**Legislation**

**Congress**

**State Assembly**
**Where Legislation**
**Sometimes Originates**
**and Federal Money Often**
**Dependent on State Money**

**Elective Process**

**Political Groups as MMPAC**

**Voting Action of Individuals**

As you can see, your PAC membership works in two ways. First, you can influence the elective process by actively supporting individual candidates and making them aware of your views. Second, you can, through your personal efforts as an informed PAC member, influence the voting action of individuals.

Remember, laws are made where lawmakers are. If medicine has a sufficient number of informed, sympathetic, effective lawmakers in office, the laws they make will obviously reflect the thinking of the medical community. It is far more important to influence legislators when they are running for office than it is to write letters to them later.

There are a number of factors which are vitally important in any election. One is voter registration. As a politically aware citizen you must be sure that all the doctors and their wives of your acquaintance are registered to vote. Secondly, you should be sure that they actually go to the polls and vote. Elementary analysis of voting returns in almost any district at random will prove to you how often voters fail to exercise their franchise.

Equally random questioning of friends and associates will reveal how little many people know about candidates and issues. A third vital factor in any election is how effectively such ignorance is counteracted. People vote for the candidate they know, the one whose name and face are familiar. Ignorance or misunderstanding of the issues often results in people voting for things they wouldn't want if they really knew what they were getting. Make sure your candidate is known and his position on the issues widely publicized.

Pollsters and political analysts tell us that most people vote for congressional candidates because someone they know asked them to. Regardless of the general public image, physicians are most often highly respected individuals in their communities. Such respect makes them well-qualified to influence people. Consider the many casual conversations you have with the gas station attendant, the barber, nurses in the hospitals, fellow members of civic committees, and many others. Make a conscious effort to influence voters in such conversations as often as possible.

So you see your MMPAC membership can ultimately have a very great effect, in a very real way, on the final result of the electoral process—legislation.

*Plan now to attend the MMPAC Luncheon at the Semiannual Meeting in Ocean City. The luncheon will be held at Convention Hall on Friday, Sept 15 at 12:00 noon.*

# SEPTEMBER 14, 15, 16, 1972
# SEMIANNUAL MEETING

**Medical and Chirurgical Faculty of State of Maryland**



Unless otherwise indicated, all meetings will be at the Convention Hall, 4000 Philadelphia Ave, Ocean City, Md

**PROGRAM**

## THURSDAY, SEPTEMBER 14

7:00 PM ORAL HYPGLYCEMIC AGENTS: THEIR PRESENT ROLE IN THE CONTROL OF DIABETES

and

MODERN CONCEPTS IN THE TREATMENT OF JUVENILE DIABETES

Speakers to be announced

Cosponsored by the Maryland Diabetes Association

## FRIDAY,SEPTEMBER 15

7:45 AM Continental Breakfast
Reservations REQUIRED — contact Faculty office

8:30 AM Parliamentary Briefing Session

9:30 AM Meeting of the House of Delegates

9:30 AM Meeting of the Woman's Auxiliary

12:30 PM MMPAC LUNCHEON — reservation form mailed under separate cover
**William H. Cooper,** MD, Washington, DC
Subject to be announced

**2:15 PM** THE ROLE OF CORONARY ARTERIOGRAPHY IN THE DIAGNOSIS AND TREATMENT OF CORONARY DISEASE
**Herbert L. Abrams,** MD, Cook Professor and Chairman, Department of Radiology, Harvard Medical School

PANEL DISCUSSION to follow

Moderator

**John B. Hearn,** MD, Department of Radiology, St. Joseph Hospital, Towson, Md

Participants

**Vincent L. Gott,** MD, Richard Bennett Darnall Professor of Surgery, The Johns Hopkins University School of Medicine

**Leonard Scherlis,** MD, Professor of Medicine and Head, Division of Cardiology, University of Maryland School of Medicine

This discussion will concern itself chiefly with the indications and usefulness of BYPASS SURGERY in coronary diseases.

6:30 PM RECEPTION AND BANQUET

Special surprise entertainment

Reservation form mailed under separate cover

## SATURDAY, SEPTEMBER 16

10:00 AM ADVANTAGES AND DISADVANTAGES OF NEUROLOGICAL CONTRAST STUDIES

**John O. Sharrett,** MD, Instructor in Neurosurgery, University of Maryland School of Medicine

**11:00 AM** MEDICAL MALPRACTICE: NO FAULT OR OUR FAULT — A panel discussion

Moderator

**W. Kenneth Mansfield,** MD, Chairman of Committee on Medical Economics, Medical and Chirurgical Faculty

Participants

**John F. King,** Esquire

**Jonas R. Rappeport,** MD, Psychiatrist for Supreme Bench of Baltimore

**Verne E. Brown,** Assistant Secretary, Home Office Claim-Loss Division, St. Paul Insurance Company

1:00 PM CRAB FEAST — Phillips Crab House

Reservation form mailed under separate cover

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The following HOTELS and MOTELS, which are in close proximity to the Convention Hall, are suggested — HOWEVER, NO ENDORSEMENT IS IMPLIED:

| | |
|---|---|
| Castle in the Sand - 37th St and Ocean | (301) 289-6846 |
| Gateway - 48th St and Ocean | (301) 289-6841 |
| Harrison Hall - 15th St and Broadwalk | (301) 289-6222 |
| Park de Ville - 55th St and Ocean | (301) 289-9151 |
| Kittiwake - 45th St and Ocean | (301) 289-6424 |
| Stardust - 32nd St and Ocean | (301) 289-6444 |
| Surf and Sand - 23rd St and Boardwalk | (301) 289-7161 |
| Quality Court - 17th St and Boardwalk | (301) 289-6868 |
| Beach Plaza Hotel - 13th St and Boardwalk | (301) 289-9121 |
| Commander Hotel - 14th St and Boardwalk | (301) 289-6166 |

MAKE YOUR RESERVATIONS DIRECTLY WITH THE ABOVE FACILITY OF YOUR CHOICE

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BE SURE TO ATTEND THIS SEMIANNUAL CONVENTION — SEPTEMBER 14, 15, 16, 1972
CONTINUING MEDICAL EDUCATION FOR ALL PHYSICIANS
RELAXATION AND FUN FOR ALL

ALBERT M. ANTLITZ, MD, Chairman
Committee on Program and Arrangements

**DBI® phenformin HCl Tablets of 25 mg.**
**DBI-TD® phenformin HCl Timed-Disintegration Capsules of 50 and 100 mg.**

*Indications:* Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
*Contraindications:* Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.
*Warnings:* Use during pregnancy is to be avoided.
*Precautions:* 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended

# Why go to the islets

Let's say you've decided that diet alone won't work in your adult-onset, nonketotic diabetic.

You're considering oral therapy for a new patient. DBI-TD or a sulfonylurea. Which?

Both lower blood sugar. But here's why DBI-TD, which is not a sulfonylurea, may be important to the dieting diabetic.

- Sulfonylureas promote release of insulin.
- Insulin is lipogenic and helps transport glucose into adipose tissue.
- Overweight patients frequently have normal or high levels of endogenous insulin.
- DBI-TD lowers blood sugar without stimulating insulin secretion from the pancreas.

Usual dosage: one 50-mg. capsule with breakfast may be effective, or a second capsule may be given with the evening meal.

**DBI-TD® Geigy**
phenformin HCl

**lowers blood sugar without raising blood insulin**

the presence of azotemia or in any clinical uation that predisposes to sustained hypoten- on that could lead to lactic acidosis. To fferentiate lactic acidosis from ketoacidosis, riodic determinations of ketones in the blood d urine should be made in diabetics previously abilized on phenformin, or phenformin and sulin, who have become unstable. If electrolyte balance is suspected, periodic determinations ould also be made of electrolytes, pH, and the ctate-pyruvate ratio. The drug should be with- awn and insulin, when required, and other rrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

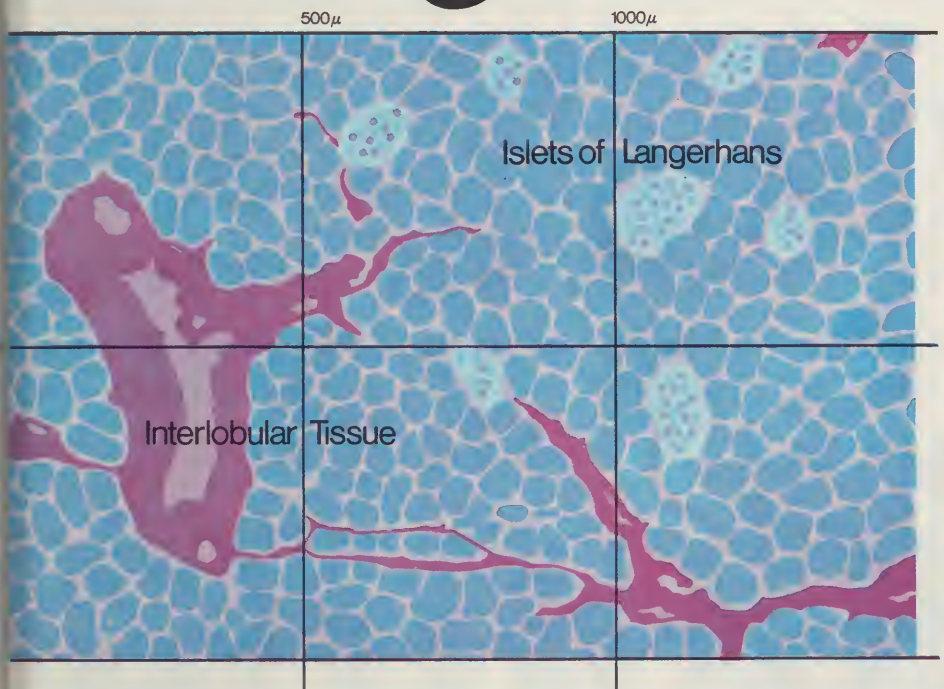
*Adverse Reactions:* Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B) 98-146-103-D (6/72)

*For complete details, including dosage, please see full prescribing information.*

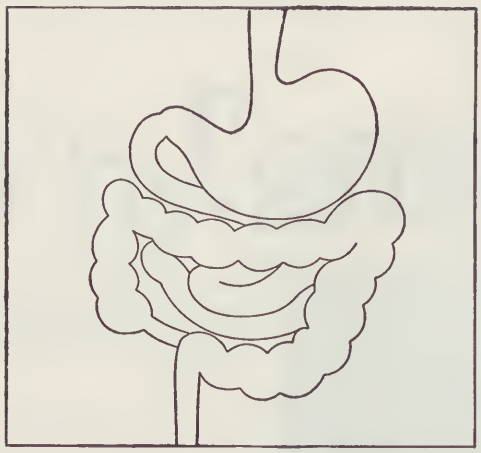
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Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

# of Langerhans?




Before using DBI-TD or any oral hypoglycemic, please read the prescribing information concerning dosage, warnings, contraindications, precautions and adverse reactions.

# in "Gasspastic" conditions



The GI tract in spasm is commonly a "gas trap."

Sidonna® is formulated to release entrapped gas, as well as to provide antispasmodic/sedative effects.

In addition to the traditional combination of belladonna alkaloids and butabarbital (warning: may be habit forming.), Sidonna contains simethicone—a non-systemic defoaming agent that "lyses" gas bubbles on contact.

Sidonna has the ability to relieve GI spasm, pain **and gas** in the irritable bowel syndrome, spastic colon, pylorospasm, gastroenteritis, gastritis, nausea, nervous indigestion, or gastric and duodenal ulcer.

**Sidonna can calm GI spasm...control anxiety...and release entrapped GI gas from the system.**

Sidonna can do more for your "gasspastic" patient. Try him on 1 or 2 tablets before meals and at bedtime.

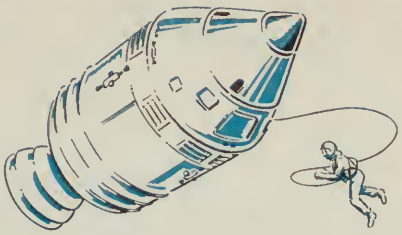
# Sidonna®

Each scored tablet contains: Specially activated simethicone 25 mg.; hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: May be habit forming.)

# can do more

**Contraindications:** Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.
**Side Effects:** Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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*Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.*

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*NOW A SUGAR-COATED TABLET*

*Each tablet contains:* METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

**Dosage:**

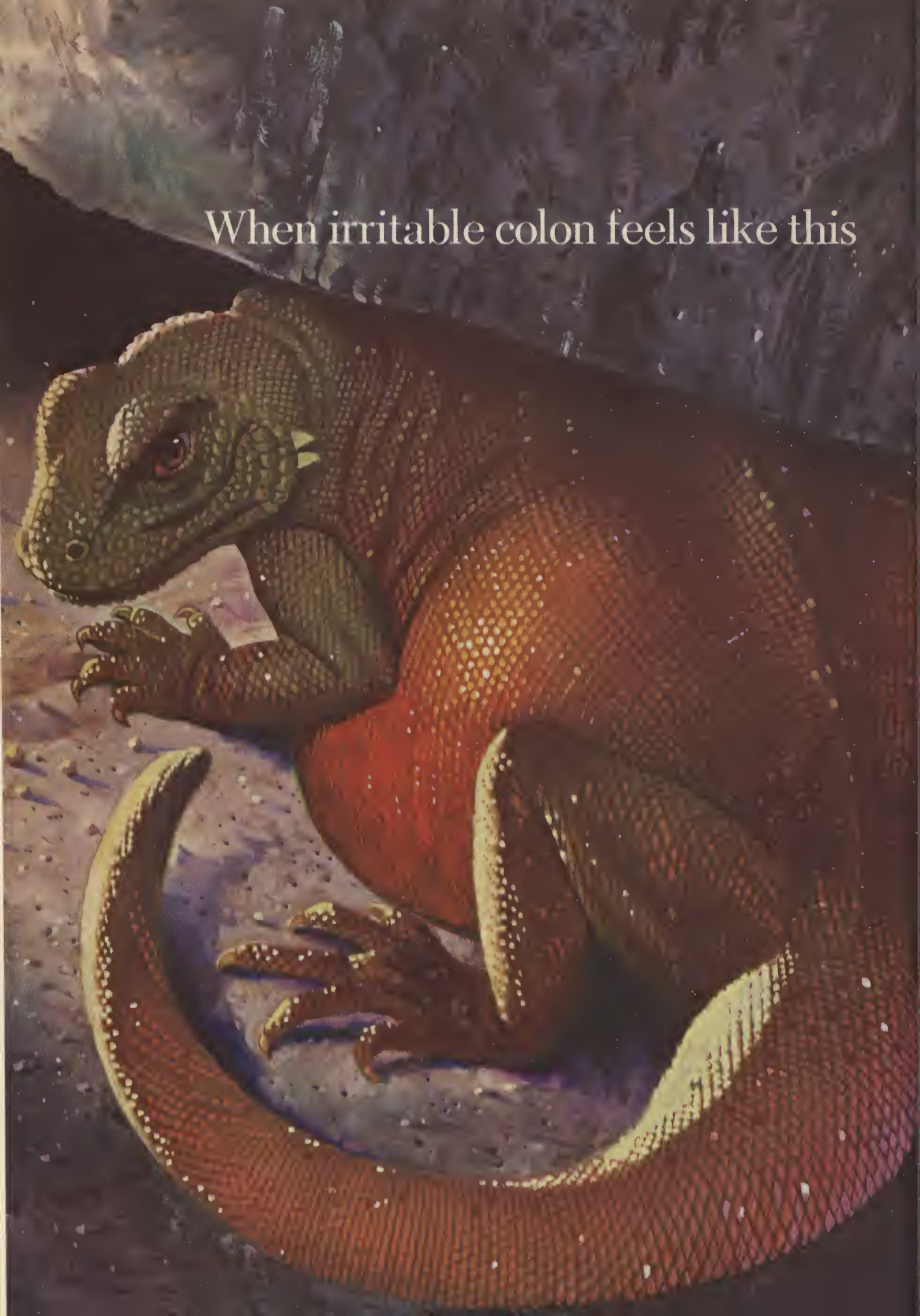
*For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.*

*2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.*

*A clinical supply will be sent to physicians and hospitals on request.*

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*Manufacturers of Ethical Pharmaceuticals*


When irritable colon feels like this

# ...in the presence of spasm or hypermotility, gas distention and discomfort, **KINESED®** provides more complete relief:

- ☐ **belladonna alkaloids—for the hyperactive bowel**
- ☐ **simethicone—for accompanying distention and pain due to gas**
- ☐ **phenobarbital—for associated anxiety and tension**

**Contraindications:** Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

**Precautions:** Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

**Side effects:** Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

**Dosage:** *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

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(from the Greek **kinetikos**,
to move,
and the Latin **sedatus**,
to calm)

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sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.

# Medical News Briefs

## Social Security and Medicare

Charging that Social Security regulations are denying medical care to Medicare recipients, DeWitt E. DeLawter, MD, president of the Medical and Chirurgical Faculty, in a recent press conference, called on the US Congress to ensure that the legislative intent of Medicare is properly and adequately carried out. Dr. DeLawter cited individuals who have been denied payment for their medical care because it was determined that regulations of the Social Security Administration do not provide for such services.

"The intent of the Medicare law was to provide medical help for people over age 65. This intent is being thwarted by governmental bureaucracy which constantly interprets the Medicare law to the detriment of the aged in our country," he said.

"In addition," Dr. DeLawter went on, "it is my belief that the Social Security Administration is, indeed, interfering in the delivery of medical care contrary to Section 1801, which specifically denies any administrative or other body with interfering in the practice of medicine."

"It is unfortunate," Dr. DeLawter indicated, "that older persons in the United States are being used as scapegoats for the shortcomings of government medicine. The costs of health care are currently one of the greatest problems confronting older persons. This, together with the lack of nutrition because of lack of funds to pay for proper diet, makes the plight of the senior citizen one that has worsened rather than improved since the passage of the Medicare law."

Dr. DeLawter cited instances where representatives of the Medical and Chirurgical Faculty, together with spokesmen for the Maryland Hospital Association, visited US Senators to appeal the arbitrary denial of Medicare benefits to the aged of Maryland.

"Retroactive denials are the biggest bugaboo the profession and hospitals have to contend with," said Dr. DeLawter. "A patient is admitted to an institution and after receiving the care is denied benefits simply because a bureaucrat has decided that persons did not need the level of care given him. As a consequence the patient is faced with payment of the bill or the hospital must absorb the cost as a bad debt. This results in higher hospital costs for the remaining segment of the population.

"Also, as a consequence, physicians are now faced with the problem of advising older patients that while they might benefit from hospitalization and, would in the medical judgment of the physician, it is possible that denial of benefits may be made by Social Security with consequent recourse to the patient for payment of the hospital bill.

"It is self-evident that you need to be a Philadelphia lawyer to work your way through the maze of regulations which are changed regularly so that the average person never knows what regulation has superseded another," Dr. DeLawter added.

While an appeal mechanism has been established so that persons can have a "fair hearing" one needs to employ an attorney to handle such an appeal. This is truly discriminatory and denies the older person access to an appeal mechanism that should be simple and easy to use.

Additional confusion is created for the aged when that individual is advised by Social Security that the charge is "in excess of Medicare Maximum Allowance." In actual fact, SSA has by regulation restricted payment of bills on two occasions. In December 1968, it placed a ceiling on fees, limiting them to the 83rd percentile of fees that prevail in a locality. In December 1970, it reduced these maximums to the 75th percentile. Already SSA has advised that it plans to limit charges to the same old rate with the new fiscal year.

"What needs to be done," said Dr. DeLawter, "is for the Social Security Administration to embark on a much needed educational program so that senior citizens are aware of what is *not covered* under the Social Security Medicare law and regulations and to remove the providers of health care from the position of having to explain denials of benefits to Maryland's senior citizens."

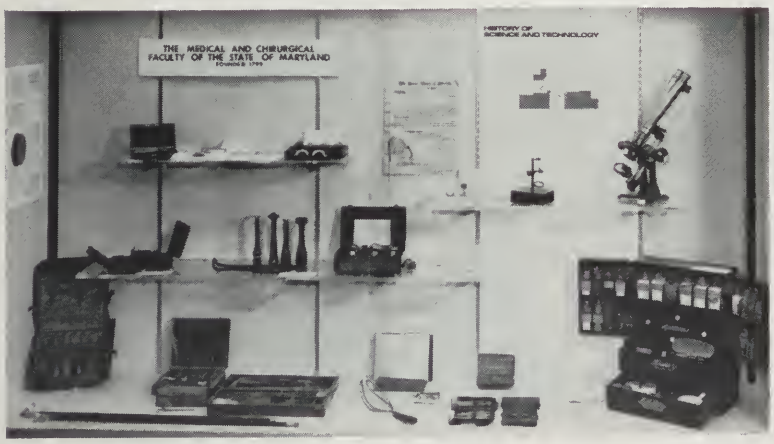
•

Obviously, if cigarette smoking can cause early death, it must have some effects on the functioning of the body which are sufficiently devastating to produce serious disease. It seems reasonable to suppose that external influences that can produce disease ought to produce effects that interfere with normal functioning long before the occurrence of frank morbidity.

Daniel Horn, PhD
—SMOKE SIGNALS



CONFEREES—Mrs. Leslie Miles, left, president-elect of the Woman's Auxiliary, and Mrs. Marvin Kolkin, president, were among representatives of more than 70 national volunteer organizations who attended a recent three-day health education conference in Chicago. While there they learned that human blight can be prevented, but that the job requires the mounting of imaginative, effective education programs. The theme of the meeting, "Health Education is the Key," opens the way to an improved quality of life for all Americans. The principal purpose of the conference was to explore means of promoting personal, family, community, and world health.




SMITHSONIAN EXHIBIT—Artifacts provided by Med-Chi were used to prepare this "Exhibit of the Month" for the Division of Medical Sciences of the Smithsonian Institution in Washington. It is now off exhibit but will be reinstalled when a new case is secured to replace the temporary one pictured here. These items are among many artifacts that have been turned over to the Smithsonian on an indefinite loan basis. All have been photographed and appropriately cataloged by the Smithsonian and records provided the Faculty.

## AABB Urges 100% Volunteer Donors

The American Association of Blood Banks (AABB), which represents a majority of the nation's nonprofit community blood banks and over 1,464 hospital blood banks, has recommended that all of its member blood banks not now obtaining 100% voluntary blood donations move as rapidly as possible toward this goal and achieve it no later than the end of 1975.

In the meantime, AABB reaffirms the need for blood nonreplacement fees and for group and individual credit as incentive for donating blood.

It also urges formation of a voluntary commission on blood banks and blood transfusion services to be comprised of representatives of the two major blood banking organizations, AABB and the American National Red Cross, as well as representatives of medical, hospital, government, and consumer organizations.

William G. Battaile, MD, AABB president says, "To assure a safe, adequate, and economical blood supply for blood transfusions, the AABB:

"Reaffirms the principle that the voluntary blood donor provides blood and blood components which are safest for patients, and urges member blood banks to move as rapidly as possible toward a goal of total voluntary blood supply.

"Recommends to its member banks who are not already providing 100% voluntarily-donated blood, the following time schedule for achieving this goal: 75% by the end of 1973, 90% by the end of 1974; and 100% by December 31, 1975."

## Memorial Lectureship to Honor Grant E. Ward

Establishment of the Grant E. Ward Memorial Lectureship was announced at the recent meeting of the House of Delegates of the Medical and Chirurgical Faculty of Maryland.

This lectureship, which will relate to "Head and Neck Surgery," has been made possible by contributions from many of Dr. Ward's former associates, patients, friends, and members of his family.

The lecture will be given at the Annual Meeting of Med-Chi, probably every second year. The Capital Fund is now sufficient to make this possible. It is hoped that the first lecture will be presented at the 1973 Annual Meeting. Any excess received will be used for expanding publications on cancer within the Med-Chi library.

A summary of the career of Grant E. Ward, MD, as read at the House of Delegates meeting on May 3, follows.

Dr. Ward was an international authority on cancer, a disease from which he died in 1958 at the age of 61. Following his graduation from The Johns Hopkins University School of Medicine in 1921, he spent five years in close association with Howard A. Kelly, MD. During this time he designed a lead cylinder for applying radium to malignancies of the surface of the body and more importantly he discovered the hemostatic effects of the electric needle. This latter method was a tremendous aid to all branches of surgery and particularly neurosurgery.

Together with another distinguished surgeon, J. Mason Hundley, Jr., MD, he organized the tumor clinic at the University of Maryland School of Medicine and subsequently organized and headed the Surgical Tumor Clinic at The Johns Hopkins Hospital, which is now known as the Grant E. Ward Tumor Clinic.

Throughout his professional career, he always had a great deal of interest in teaching students and house officers and in assisting the latter with unusual operations. The house staff loved and admired him, as did his associates, nurses, and patients. He was never too hurried to lend a helpful hand and always was kind and tolerant.

Grant Ward was not a well man during the last 20 years of his life. In 1940 he had an ileostomy for chronic ulcerative colitis. In 1942 a tumor was removed from his cervical spinal cord and he was left with a partial, but grave, paralysis of his right arm and had repeated bouts of thrombophlebitis. The ileostomy bag, the right arm-body harness (which would have taxed a gladiator), and the rubber stockings would have caused most people to call it quits, but not Grant. He further educated his left hand and reeducated his right and continued as though nothing had happened. One day, at the end of an eight-hour operation, he was asked how he stood it and if he were not tired and he replied simply, "I do not allow myself to think about it." He was a living example of the fact that courage is a major virtue and that all things work together for good to one who is unafraid.

Despite these many handicaps, Grant led a most productive and useful life.

He published two books and approximately 100 scientific articles, many of which dealt with cancer. He was active in medical and civic affairs. He was vice president of our state organization on two occasions and was a president of the Baltimore City Medical Society.

He was president and chairman of the Board of Directors of the Maryland Chapter, American Cancer Society; and was particularly interested in his church activities. He was led by his Christian faith and understood the importance of the spiritual as well as the physical well-being of his patients.

The Evening Sun of Feb 17, 1958 had this to say of him:

"Not always does a man who achieves eminence in his profession also reach quite the same greatness of spirit and character. Dr. Grant E. Ward did. His brilliance as a surgeon was a two-fold gift. He gave life to many for whom there would have been little hope in less skilled hands. And he inspired and taught thousands of his colleagues who have been better doctors for having learned from him.

"Coupled with his professional skill was a compassionate heart and a great courage that carried him through crises which would have defeated a lesser man. The operation which left him with a crippled right hand midpoint in his career served only as a spur. He devised a harness of steel and leather to perform the function of his useless muscles. He developed additional dexterity with his left hand.

"Faith was, perhaps, the great cement which bound these qualities of spirit and ability together and Dr. Ward freely acknowledged his faith. His death at 61 was premature. But what man would wish to accomplish more in that span of years."

## DHEW Conducts Health Survey

About 350 persons from one to 74 years of age from Worcester County in Maryland and Sussex County in Delaware and some 440 persons of similar age from Montgomery and Prince George's counties in Maryland and the District of Columbia are being invited to receive health and nutrition examinations in a study beginning Aug 12 and ending Sept 16, 1972.

The survey will examine a representative sample of the US population over the next two years, visiting 64 locations throughout the country for this purpose. The survey will be collecting uniform statistical information on selected chronic disease conditions and on the nutritional status of the population. Persons to be examined are selected by scientific sampling techniques and invited to participate in the data-collecting process. Examinations are conducted at the survey's mobile examination center, which will be set up at a central location.

Each examination team consists of a general examining physician, dermatologist, ophthalmologist, dentist, nurse, laboratory technician, two health technicians, secretary, three nutritionists, and supporting staff of administrative personnel and interviewers.

All data and information collected from those individuals participating in the survey are used for statistical purposes only and are strictly confidential. A copy of examination findings, including laboratory findings (hemoglobin, red and white cell counts, cholesterol, iron, vitamin levels, etc) may be made available to an examinee's personal physician or clinic physician should this be requested and authorized by the examinee. Findings of the examination are not made available to the examinee by the examining staff, but rather through his physician, who is best able to interpret the findings and possible significance of such for the individual involved.

Operationally, the survey is preceded in each area by interviewers from the Bureau of the Census, who visit selected census tracts for the purpose of identifying the eligible persons and collecting related information. From this list of eligibles, a number of sample persons is selected and later contacted by Health and Nutrition Examination representatives, who explain the survey, seek authorization for participation, and arrange appointments for the examination and transportation. No charge is made for the examination and transportation provided to and from the mobile examination center.


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Fri. & Sat.
Dinners 5 PM-11:30 PM
Sun. Dinner 4 PM-10:30 PM

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## ACEP Seeks Scientific Papers and Exhibits

Two new features are planned for the Fourth Annual Scientific Assembly to be sponsored by the American College of Emergency Physicians in San Francisco Nov 8-10. They are the inclusion of original scientific papers (in addition to the featured speakers) and of scientific exhibits.

Scientific papers must represent original work by the author which is directly related to some aspect of emergency care. The paper may deal with the provisions of emergency care, the improvement of such care within the emergency department, or the emergency treatment of a disease. The paper may not have been previously published. Those papers that are accepted for presentation will be simultaneously considered for publication in *JACEP,* the Journal of the American College of Emergency Physicians.

Abstracts and information on the contents of proposed scientific exhibits should be submitted to Eugene C. Nakfoor, MD, American College of Emergency Physicians, 241 E Saginaw, East Lansing, Mich 48823.


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## AMA-ERF Medical School Grants Made

Formal presentation of checks totaling some $25,000 was made to the deans of the two Maryland medical schools during the Presidential Banquet of the 174th Annual Meeting of Med-Chi.

These AMA-ERF grants were part of the 122 checks totaling $1,108,247 sent to state medical associations for presentation to the medical school deans in their respective states. This represented an increase of $152,521 over last year's total.

These unrestricted grants from the AMA-ERF represented earmarked gifts from physicians, the Woman's Auxiliary, and alumni in Maryland and the nation in 1971.

Another example of AMA-ERF support to medical education is the Loan Guarantee Program instituted in 1962. Since that date, the AMA-ERF has guaranteed 46,046 loans totaling over $51,703,775 to students, interns, and residents.

Since the beginning of this program, it has been necessary for the AMA-ERF to purchase from the participating banks 741 defaulted loans totaling $2,025,270. Causes of default, in order of frequency, are slow pay, military service, death, bankruptcy, and dropouts.

Additionally, the AMA each year appropriates over $1,700,000 in support of its Division and Council on Medical Education.

The AMA's accreditation, undergraduate, graduate, continuing and allied education programs have played a major role in establishing and maintaining the preeminence of medical education in the United States.

After citing these and other statistics, John M. Chenault, MD, chairman of the AMA-ERF Education and Research Foundation, in a letter to all doctors closed as follows:

"Once again we are inviting you to participate in AMA-ERF programs — if, in 1972, the American Medical Association Education and Research Foundation is to exceed its 1971 contributions to medical education, expand its Loan Guarantee Program and Opportunity Loan Guarantee Program to disadvantaged, needy students, as well as becoming involved in a variety of other worthwhile programs designed to improve the quality and availability of medical services to all segments of our population.

"The AMA-ERF needs your continued support. Please give generously."



SMILES are in evidence and with good reason as John F. Schaefer, MD, center, Faculty president, hands AMA-ERF checks to Russell Morgan, MD, dean of The Johns Hopkins School of Medicine, right; and John H. Moxley, III, MD, dean of the University of Maryland School of Medicine.




FUND RAISERS—Funds for medical schools and the Student Loan Fund were the key words in "Your AMA-ERF Nook" at the Baltimore Civic Center during the 174th Annual Med-Chi Meeting May 3-5. ERF chairmen and acting chairmen from eight component auxiliaries, members-at-large, and Med-Chi's Mrs. Anna Wynde Leake efficiently staffed the exhibit, serving generous portions of ERF information to physicians, medical students, visitors, and guests. Proceeds from the sale of merchandise pictured here were divided between the University of Maryland and Johns Hopkins medical schools. Mrs. W. Carl Jennette, left, Carroll County ERF chairman, and Mrs. Elmer G. Linhardt, state chairman, AMA-ERF, are shown "minding the ERF store."

# MINUTES

## First Meeting, 174th Annual Session, House of Delegates (274th meeting)

## Medical and Chirurgical Faculty of the State of Maryland Wednesday, May 3, 1972

## Baltimore Civic Center, Baltimore, Md.

The 274th meeting, first of the 174th Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was called to order at 9:45 AM Wednesday, May 3, 1972, at the Baltimore Civic Center, Baltimore, Md, the president and secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors:

Manning W. Alden, Council
William A. Andersen, Baltimore Co.
Charles Bagley, III, Wicomico Co.
Timothy D. Baker, Baltimore City
John G. Ball, Council
George S. Banning, Jr., Pr. Geo. Co.
Richard D. Bauer, past president
*Horace W. Bernton, Mont. County
Francis J. Borges, Baltimore City
M. McKendree Boyer, Council
Henry A. Briele, Council
James B. Brooks, Council
*Herman Brecher, Baltimore City
Robert vL. Campbell, Council
D. Delmas Caples, Baltimore County
John T. Chissell, Council
Arthur E. Cocco, Baltimore County
Archie Robert Cohen, Washington Co.
Edward F. Cotter, Baltimore City
William B. Culwell, Carroll County
Richard Y. Dalrymple, Council
Melvin B. Davis, Baltimore County
Matthew Debuskey, Baltimore City
DeWitt E. DeLawter, Council
John M. Dennis, Council
Marshall A. Diamond, Mont. Co.
*Frederick Y. Donn, Montgomery Co.
Wm. Carl Ebeling, Council
Wolcott L. Etienne, Council
John F. Eyring, Jr., Baltimore City
Robert W. Farr, Kent County
George G. Finney, Jr., Baltimore City
Ronald H. Fishbein, Baltimore City
Elliott R. Fishel, Baltimore City
Russell S. Fisher, Council
Herbert H. Leighton, Garrett
*Leon R. Levitsky, Prince George's County
*Gina M. Glick, Allegany County
L. Michael Glick, Allegany County
Robert B. Goldstein, Council
Edward G. Grau, Baltimore County
George H. Greenstein, Baltimore City
J. Roy Guyther, St. Mary's County

Doctors:

William B. Hagan, Council
Louis E. Harmon, Baltimore City
John Collins Harvey, Council
Thomas Franklyn Herbert, Howard County
Philip W. Heuman, Council
Charles Earl Hill, Anne, Arundel County
Claude D. Hill, Baltimore City
John B. Imboden, Baltimore City
Alfred E. Iwantsch, Baltimore County
J. Parran Jarboe, Council
Frederick M. Johnson, Charles County
D. Frank Kaltreider, Council
*Bernard S. Karpers, Jr., Baltimore City
Arthur T. Keefe, Jr., Council
Seruch T. Kimble, Council
Howard F. Kinnamon, past president
Louis J. Kolodner, Council
J. Richard Lilly, Prince George's Co.
Emory J. Linder, Harford County
Elmer G. Linhardt, Bd. of Med. Ex.
Francis C. Mayle, Jr., Montgomery Co.
Karl F. Mech, Council
B. Martin Middleton, Council
Benjamin H. Minchew, Howard County
Donald W. Mintzer, Baltimore City
Andrew C. Mitchell, Wicomico County
Marvin I. Mones, Montgomery County
Charles F. O'Donnell, Council
Hilary T. O'Herlihy, Anne Arundel Co.
Stephen K. Padussis, Baltimore City
A. Austin Pearre, past president
M. C. Porterfield, Carroll County
Belden R. Reap, Montgomery County
J. Morris Reese, Council
William F. Renner, Baltimore City
*Jimmie Lee Rhyne, Baltimore City
Peter W. Rieckert, Dorchester Co.
James A. Roberts, Montgomery Co.
William Roemmich, Baltimore Co.
Edwin Ruzicka, Talbot Co.
Hugo A. Sacchet, Washington Co.
John F. Schaefer, Council
J. Thomas Schnebly, Montgomery Co.
Margaret Lee Sherrard, Balto. Co.
R. Kennedy Skipton, Prince Geo. Co.
George I. Smith, Jr., Frederick Co.
Gordon M. Smith, Montgomery Co.
Roland T. Smoot, Baltimore City
*Stanley R. Steinbach, Baltimore City
Aaron C. Sollod, Baltimore City
George R. Spence, Montgomery Co.
Raymond P. Srsic, Anne Arundel Co.
*Henry H. Startzman, Jr., Baltimore City

Doctors:

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*Theodore F. Toulan, Baltimore County
Francis J. Townsend, Jr., Council
Richard F. Tyson, Baltimore City
*John B. Umhau, Jr., Montgomery Co.
Thomas E. Van Metre, Jr., Baltimore City
*B. B. Velez, Baltimore County
Sidney J. Venable, Baltimore Co.
Philip F. Wagley, Council
Hugh W. Ward, Calvert County
*Walter R. Welzant, Baltimore County
Lawrence R. Wharton, Jr., Baltimore City
Merton L. White, Montgomery County
*Henry L. Wollenweber, Baltimore City
N. Louise Young, Baltimore City
Raymond N. Yow, Council
Charles E. Wright, Frederick County

Present also were staff personnel.

**Invocation**

Archie R. Cohen, MD, chairman of the Faculty's Committee on Medicine and Religion, delivered the invocation.

**Secretary Pro-tem Named**

By unanimous consent Manning W. Alden, MD, was appointed to serve as secretary pro-tem during the session in the absence of William A. Pillsbury, MD.

**Announcements**

The president made several announcements regarding the manner of conducting the business of the session.

**Minutes**

The minutes of the House of Delegates, Semiannual Session, Baltimore, Md, on Saturday, Sept 11, 1971, having been distributed to members and having been approved by the Executive Committee, were presented to the House for information.

**Introduction of Guests**

Darrell C. Crain, MD, president, Medical Society of District of Columbia; George P. Rosemond, MD, president, Pennsylvania Medical Society; William S. Hotchkiss, MD, president of the Virginia Medical Society; and Harry S. Weeks, Jr., MD, president of the West Virginia Medical Society, were all introduced to the House, some of whom spoke briefly.

**Necrology**

After the secretary read the following names of deceased members, the members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues:

| | |
|---|---|
| Allegany County | |
| Rathbone, R. F. | Feb 11, 1972 |
| Baltimore City | |
| Benz, Carl F. | Oct 11, 1971 |
| Buchness, Anthony V. | Feb 13, 1972 |
| Colston, J. A. Campbell | July 21, 1971 |
| Dobihal, Louis Charles | Feb 6, 1972 |
| Flanagan, Edward Anthony | May 11, 1971 |
| Goldmann, Harry | June 7, 1971 |
| Gould, John Joseph | Nov 16, 1971 |
| Jensen, Jacob Roed | Nov 19, 1971 |
| Kitlowski, Edward A. | July 3, 1971 |
| Laukaitis, Joseph G. | Dec 26, 1971 |
| Merkel, Walter C. | Feb 1, 1972 |
| Murray, John G., Jr. | Aug 14, 1971 |
| Niblett, Walter S. | May 21, 1971 |
| Phelps, Winthrop M. | Oct 31, 1971 |
| Reckling, Ralph W. | March 28, 1971 |
| Richardson, Edward H. | Jan 15, 1971 |
| Saar, Artur | March 23, 1971 |



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| | |
|---|---|
| Saunders, LeRoy W. | March 9, 1971 |
| Skloven, Joseph | April 9, 1971 |
| Wohl, Milton J. | Nov 17, 1971 |
| Ogden, Frank N. | April 17, 1972 |
| Phillips, Frederick | April 5, 1972 |
| Baltimore County | |
| Beitler, Frederic V. | July 1, 1971 |
| Bronillet, George H. | March 3, 1972 |
| Morrison, W. Herbert | Feb 13, 1971 |
| Snyder, John N. | Dec 11, 1971 |
| Cecil County | |
| Richards, G. Hampton | March 7, 1971 |
| Dorchester County | |
| De LaGuardia, Miguel A. | June 24, 1971 |
| Harford County | |
| Horky, J. Ralph | Oct 27, 1971 |
| Howard County | |
| Shipley, Frank E. | April 2, 1971 |
| Kent County | |
| Burkett, Wendell J. | Nov 26, 1971 |
| Montgomery County | |
| Edison, Thomas G. | Nov 28, 1971 |
| Prince George's County | |
| Burns, Cornelius J. | April 1, 1971 |
| St. Mary's County | |
| Greenwell, Charles | Oct 11, 1971 |
| Somerset County | |
| Gentry, Thomas C. | Dec 7, 1971 |
| Talbot County | |
| Baker, J. Tyler | March 7, 1972 |
| Wright, Jessie | Sept 6, 1970 |
| Washington County | |
| Hiehle, Wilbur W. | March 24, 1972 |
| Affiliates | |
| Chase, James M., Jr. | Feb 18, 1971 |
| Hemminger, Earl Wentworth | Oct 29, 1971 |
| Lawrence, Carteret | Nov 24, 1971 |
| Emeritus at Large | |
| Gerstley, Manfred J. | July 27, 1971 |

### Presentation of 50-year Pins and Certificates

The president awarded 50-year pins and certificates to the following members who were present for the meeting:

J. Morris Reese, MD, Lutherville
William D. Noble, MD, Easton

Fifty-year certificates will be mailed to those members unable to be present who are:

Leo Brady, MD, Scottsdale, Arizona
Samuel Whitehouse, MD, Baltimore
Leslie E. Daugherty, MD, Cumberland
Philibert Artigiani, MD, Baltimore

### Emeritus Membership

On motion of the council chairman, Dr. Alden, the following members who had received the recommendation of their component societies and the Council, were elected to Emeritus Membership in the Faculty:

Baltimore City

Emmanuel A. Schimunek, MD
Jacob M. Miller, MD
Helen B. Taussig, MD
James A. McCallum, MD
James K. Insley, Jr., MD (all of Baltimore)

Montgomery County

William S. Murphy, MD, Rockville
Robert A. Bier, MD, Silver Spring

### Treasurer's Report and 1972 Budget

Karl F. Mech, MD, treasurer, presented the 1972 budget for information of the House, this having been adopted by the Council. The treasurer advised that the Faculty's books had been audited and that the printed audit report would be available at the Semiannual Session.

### Grant E. Ward MD Memorial Lecture Fund

The treasurer then reported that the sum of $5,000 had been contributed to the Faculty for establishment of the Grant E. Ward, MD, Lecture Fund. He then outlined a brief history of Dr. Ward and his accomplishments.

### Bylaws Committee Report

Charles F. O'Donnell, MD, chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than the required two thirds vote:

(a) Amend Article XI, by inserting a new Section 5 to read as follows:

> Section 5. A COMMITTEE ON EMERGENCY MEDICAL SERVICES composed of those physician representatives of all hospitals in Maryland desiring to participate in this activity shall be appointed by the president who shall also designate the chairman. This Committee shall develop action programs in emergency medical services to meet the state's needs and maintain liaison with groups at all levels concerned with such services. It shall strive for continued improvement in the emergency care provided members of the public; shall develop and present educational programs in this regard; and shall make recommendations in cooperation with other concerned groups and individuals for remedial actions where deemed necessary. It shall also attempt to coordinate, wherever possible, similar activities being carried out by like committees of other organizations.

(b) Amend Article XI, Section 9, by substituting for it the following language:

> Section 18. A COMMITTEE ON JOINT PRACTICES, shall consist of at least five members appointed by the president. This Committee shall meet jointly with representatives of other professional groups and respective licensure boards to discuss areas of mutuality of practice; and to recommend changes in joint practices for the improvement of patient care. It shall make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care with particular attention to the rise of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and para-professions in areas long assumed to be the concern solely of the physician and/or the nurse. Health management executives, other professions, and allied health personnel, as well as groups involved in health care may be invited to join in planning for optimum working relationships and concerted role performance that will assure the best delivery of quality health care.

(c) Amend Article XI, Section 17, by inserting the words, "at least" between the word "of" and "nine" in the second line of this section and by adding a new sentence to read as follows: "Any party aggrieved by the action of local Peer Review Committees may, within 30 days of such action, file an appeal in writing with the Peer Review Committee which shall hear the appeal."

(d) Amend Article XV by striking out "Robert's Rules of Order Revised" and inserting the "current edition of *Robert's Rule of Order Newly Revised*."

The House then, by unanimous consent, granted the request of the Committee to secretarially renumber the sections of Article XI on Committees so as to arrange them in alphabetical order.

**Resolution 1A/72 Adopted**

Dr. Alden, on behalf of the Council moved adoption of Resolution 1A/72, which was adopted and reads as follows:

WHEREAS, The Medical Profession is the target of many pressures and discriminatory practices, (ie, the physician draft, Phase II Price Controls); and

WHEREAS, The present structure of the AMA is not legally able to represent physicians in collective bargaining or class suits; and

WHEREAS, There is a growing demand from individual physicians that effective measures be taken on behalf of the medical profession; therefore, be it

*Resolved*, That the AMA Delegates from Maryland introduce a resolution at the next meeting of the AMA House of Delegates calling for the establishment of a study commission to determine the most effective legal way to permit collective bargaining and the institution of class actions on behalf of the medical profession in the United States.

**Substitute Resolution 1A/71 Tabled**

Dr. Keefe, on behalf of the Policy and Planning Committee, reported back resolution 1A/71 which had been referred to the Committee, and, on its behalf offered the following substitute which was laid on the table together with Resolution 1A/71.

WHEREAS, In 1962, as a result of a Professional Management Study, the Faculty considered the question of hiring a professional negotiator; and

WHEREAS, Many convincing arguments were presented at that time for the Faculty to take such action, including:

(a) Negotiation is a highly skilled art requiring special knowledge and training.

(b) The Government and other parties are always represented by a professional negotiator.

(c) Medical and Chirurgical Faculty in the past, has been represented by committees of physicians, who, by and large, are untrained in negotiating skills.

(d) The committees change from time to time preventing any real continuity on a year-to-year basis.

(e) It will provide a consensus for the profession, whereas decisions are sometimes not reached for the benefit of the majority.

(f) Such a negotiator would know the appropriate time to reach a compromise in the best interests of the public.

(g) Continued contact with persons "on the other side" would make negotiation easier and more constructive.

and

WHEREAS, These arguments are still valid and, perhaps more so, because of the increasing number of prepayment mechanisms that are coming into play; and

WHEREAS, An increasing amount of assistance must be provided to members of the Medical and Chirurgical Faculty to help:

(a) Design means of case appeals when legal action is necessary,







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(b) Be a representative for the profession in situations requiring arbitration or where the potential exists for limiting, controlling, negating or abolishing professional rights,

(c) Attend to specific areas of differences with negotiations involving third-party insurance carriers, Phase II of federal governmental price controls (or any successor thereto); as well as to provide interpretations of governmental regulations,

(d) Collate data regarding legal and regulatory governmental controls on medicine (eg, keeping abreast of changes in the Medicare law, as well as tracing the authority for such regulations or directives as well as the interpretations of such items by third-party carriers),

(e) At request of individual members of the Faculty prepare or produce data for concise, logical presentation of a claim or complaint and intercede on his behalf as needed; and

WHEREAS, Such a person could perform other collateral duties as required or needed in areas such as determination of legality of ethical decisions of the Faculty, provision of legal opinions regarding problems physicians encounter in their practice, drafting of legislation and interpretation of bills before the General Assembly; and

WHEREAS, Such an individual should demonstrate enthusiasm and originality in addition to having a loyalty to the medical profession; should have a fresh innovative approach, which would be a premium characteristic; should be provided with sufficient remuneration so that his interest and loyalty might not be divided; therefore be it,

*Resolved,* That the Council of the Medical and Chirurgical Faculty of the State of Maryland be directed to seek out and employ qualified legal counsel in whose charge would be placed the responsibility for dealing with third-party payment mechanisms under the policy direction of an appropriate committee; and be it further

*Resolved,* That the duties and responsibilities of such an individual include other related socioeconomic matters deemed appropriate by the Council.

### Building Committee Report Adopted

Dr. Fisher, on behalf of the Ad Hoc Committee on New Faculty Building, moved the adoption of the following motion, which after debate and amendment, was adopted:

That the Ad Hoc Committee on a New Faculty Building is hereby authorized to purchase in the name of the Medical and Chirurgical Faculty at least ten but not more than 20 acres of land at the conflux of Routes 29, 40 and 70N located in Howard County, with the exact location of the land to be determined in negotiation with the principals at a price of $10,000 per acre.

### AMA Trustee Addresses House

Robert B. Hunter, MD, of Washington, a member of the AMA Board of Trustees, addressed the House of Delegates regarding AMA policies and offered to answer any questions members might have.

### Governor's Veto of HB 573

On motion of Dr. Davis, after debate, the following motion was adopted:

That the Governor be urged to veto HB 573

### Nominating Committee Report

Henry A. Briele, MD, chairman of the Nominating Committee, presented the following slate:

President-elect
William Carl Ebeling, Towson
(President-elect 1972-73)
(President 1973-74)

First Vice President
Carolyn H. S. Pincock, Silver Spring (1974)

Second Vice President
Manning W. Alden, Annapolis (1974)

Third Vice President
William G. Speed, III, Baltimore (1974)

Secretary
William A. Pillsbury, Timonium (1974)

Treasurer
Karl F. Mech, Baltimore (1974)

Councilors
Central District
Robert B. Goldstein, Baltimore (1976)
D. Frank Kaltreider, Baltimore (1976)
Donald J. Roop, Towson (1976)
John O. Sharrett, Baltimore (1976)
Philip F. Wagley, Baltimore (1976)
Eastern District
Arthur T. Keefe, Jr., Chestertown (1976)
South Central District
Charles H. Ligon, Sandy Spring (1976)
Marvin I. Mones, Silver Spring (1976)
Carolyn H. S. Pincock, Silver Spring (1972-73)

Delegate to the American Medical Association
Russell S. Fisher, Baltimore
(Jan 1, 1973—Dec 31, 1975)

Alternate Delegate to the American Medical Association
M. McKendree Boyer, Damascus
(Jan 1, 1973—Dec 31, 1975)

Committee on Program and Arrangements
John H. Tuohy, Bethesda (1972-76)
Laurence R. Gallager, Columbia (1973-77)

Library and History Committee
Roland T. Smoot, Baltimore (1973-78)

Finney Fund Committee
James P. McCarrick, Rockville (1973-78)

Board of Medical Examiners
Archie R. Cohen, Clear Spring (June 1972-June 1976)
Karl F. Mech, Baltimore (June 1972-June 1976)
John F. Schaefer, Baltimore (June 1972-June 1974)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, immediately following adjournment of the first meeting of the session.

The Board of Medical Examiners are to be elected at the General Session, Thursday, 12 noon, May 4, 1972, at the Baltimore Civic Center.

### Fixing Time for Second Meeting

By unanimous consent, the House directed that the second meeting of the Annual Session be held five minutes following the adjournment of the first meeting.

### Announcements

Certain other announcements were made and there being no further business, the president, by unanimous consent, declared the House adjourned at 11:55 AM until 12:10 PM, Wednesday, May 3, 1972, at the Baltimore Civic Center.

MANNING W. ALDEN, MD, Secretary Pro-tem

# MINUTES

**Second Meeting, 174th Annual Session, House of Delegates (275th meeting)**

**Medical and Chirurgical Faculty of the State of Maryland, Wednesday, May 3, 1972**

**Baltimore Civic Center, Baltimore, Md.**

The 275th meeting, second of the 174th Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was called to order at 12:10 PM on Wednesday, May 3, 1972, at the Baltimore Civic Center, Baltimore, Md, the president and secretary being present.

The same persons attended the 275th meeting as had attended the 274th meeting. (See Minutes of the 274th meeting for complete listing.)

### Election of Officers

There being no candidates nominated from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent, the ballot was dispensed with.

The slate nominated at the 274th meeting was then elected by voice vote. (See Minutes of the 274th meeting for complete listing.)

The president, by general consent, declared the House adjourned, sine die at 12:15 PM.

MANNING W. ALDEN, MD, Secretary Pro-tem




**REVIEW OF MEDICAL MICROBIOLOGY, by Ernest Jawetz, MD; Joseph L. Melnick, PhD; and Edward A. Adelberg, PhD, Lange Medical Publications, Los Altos, Calif, 1972.**

The authors' intention in preparing this review has been to make available a reasonably comprehensive, accurate, up-to-date presentation of those aspects of medical microbiology which are of particular significance in the fields of clinical infections and chemotherapy. It is directed at the medical student, house officer, and practicing physician. A considerable portion of this tenth edition has been devoted to a discussion of basic science, thus extending the usefulness of the book to students in introductory microbiology as well.



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—we prepare a CONFIDENTIAL COST ANALYSIS

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**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

**IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media. Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.**

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

**Contraindications:** Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

**Warnings:** Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

**Precautions:** Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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Gantrisin reaches its sites of action quickly. Measurable levels of the drug have been found in blood and urine within 60 minutes; in 2 to 3 hours, therapeutic levels usually have been reached.

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Gantrisin's rapid excretion rate is another reason why it is generally well tolerated. Over 50% of a single oral dose is excreted in 8 hours, over 90% in 24 to 48 hours, so there is little risk of hematuria or crystalluria, and anuria is rare. As with all sulfonamides, adequate fluid intake must be maintained. Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

**For nonobstructed cystitis due to *E. coli* and other susceptible organisms**

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**Usual adult dosage:**
4 to 8 tablets *stat*
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# AAMA

### Maryland

The 12th Annual Meeting of the Maryland American Association of Medical Assistants was held on May 9 at the Penn Hotel in Towson. There was a morning registration and business meeting at which the following officers were elected:

President, Mabel Young, Cumberland
President-elect, Dorothy Walker, Baltimore
Vice president, Eleanor Stuck, Baltimore
Treasurer, Mary Minnick, Cumberland
Recording Sec., Mary Shimer, Anne Arundel
Corresponding Sec., Ann Shultz, Baltimore

Delegates to the national convention are:
Mabel Young, Cumberland
Dorothy Hartel, Baltimore
Jean Subock, Anne Arundel

Elected as alternate delegates were Dorothy Walker and Eleanor Stuck of Baltimore, and Pat Kalnoske of Anne Arundel.

A panel discussion on "Medicine, Morals, and Malpractice" was moderated by Russell S. Fisher, MD, chief medical examiner for the State of Maryland. Panelists included Thomas Young, Esq., assistant attorney, State of Maryland; and John D. Hunter, chief enforcement officer for the Insurance Division of the Maryland Department of Licensing and Regulation.

Master of ceremonies for the evening banquet, which had a gay carnival theme, was Stephen B. Hiltabidle, MD, of Annapolis.

A candle installation service was conducted by Dorothy Hartel.

### Baltimore Chapter

Howard J. Garber, MD, MPH, was the guest speaker at the May 9 meeting in the medical examiner's office.

Dr. Garber's presentation of "Laboratory Diagnosis of Infectious Diseases" was most interesting and informative. He included the rubella vaccine, toxoplasmosis, and the heavy increase of venereal diseases. Dr. Garber's use of colorful slides was most impressive.

A native of Cleveland, Dr. Garber came to Baltimore in 1966 when he was assigned by the US Public Health Service to the Maryland State Department of Health for two years. In 1969 he received his MPH in Public Health at Johns Hopkins and became chief of the Division of Communicable Diseases of the Maryland State Department of Health, where he directed the state's VD and immunization programs. He is currently in private practice of Internal Medicine in Baltimore County.

# PEER REVIEW

This is the second in a series of articles written in an attempt to keep the general membership apprised of the activities of the Peer Review Committee of the Medical and Chirurgical Faculty of the State of Maryland.

The case to be presented affords an opportunity to partially differentiate between the function of the Hospital Utilization Review Committee and that of the Peer Review Committee. The question frequently arises as to whether there is a need for both. In the case to follow, this question will be answered at least to some degree.

The insurance carrier brought this case to the attention of the committee. The carrier questioned the need for the special services provided the patient after reviewing the hospital records. The patient, a middle-aged woman, was hospitalized in late July 1971 with a left breast mass. After undergoing the usual work-up and preparation, she was operated on and found to have carcinoma of the breast on frozen section. A radical mastectomy was performed and no difficulties were encountered during the procedure. Postoperatively, the patient received around-the-clock private duty nurses although there were no complications; and none were anticipated on the basis of the history, physical or preoperative investigation. Furthermore, the 24-hour private duty nursing service continued to the time of discharge of the patient from the hospital one week later. These facts were supplied by the regional representative of the insurance company and confirmed by committee review of the hospital records.

After reviewing the arguments pro and con, it was the opinion of the committee that the insurance carrier was justified in the questions he raised concerning the need of expensive and specialized care in this instance. The committee felt that private-duty nursing care was not warranted beyond the immediate postoperative period, especially since the patient's condition was listed on the hospital records as being satisfactory. The committee also expressed the opinion that the carriers do have a responsibility to make clear to their subscribers that extras, such as private-duty nursing, are available only "if medically necessary." It was felt that many subscribers assume this is a right to a benefit which they are entitled to collect, regardless of medical indication.

The carrier was informed of the above findings.

EARL C. CLAY, JR, MD
Member, Peer Review Committee

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# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. Has recurrent trichomoniasis and Monilia.

Indicates estrogen deficiency and excess of progestogen in current O.C.

1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E*** or **Ovulen*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.

Indicates probable need for more estrogen.

1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.

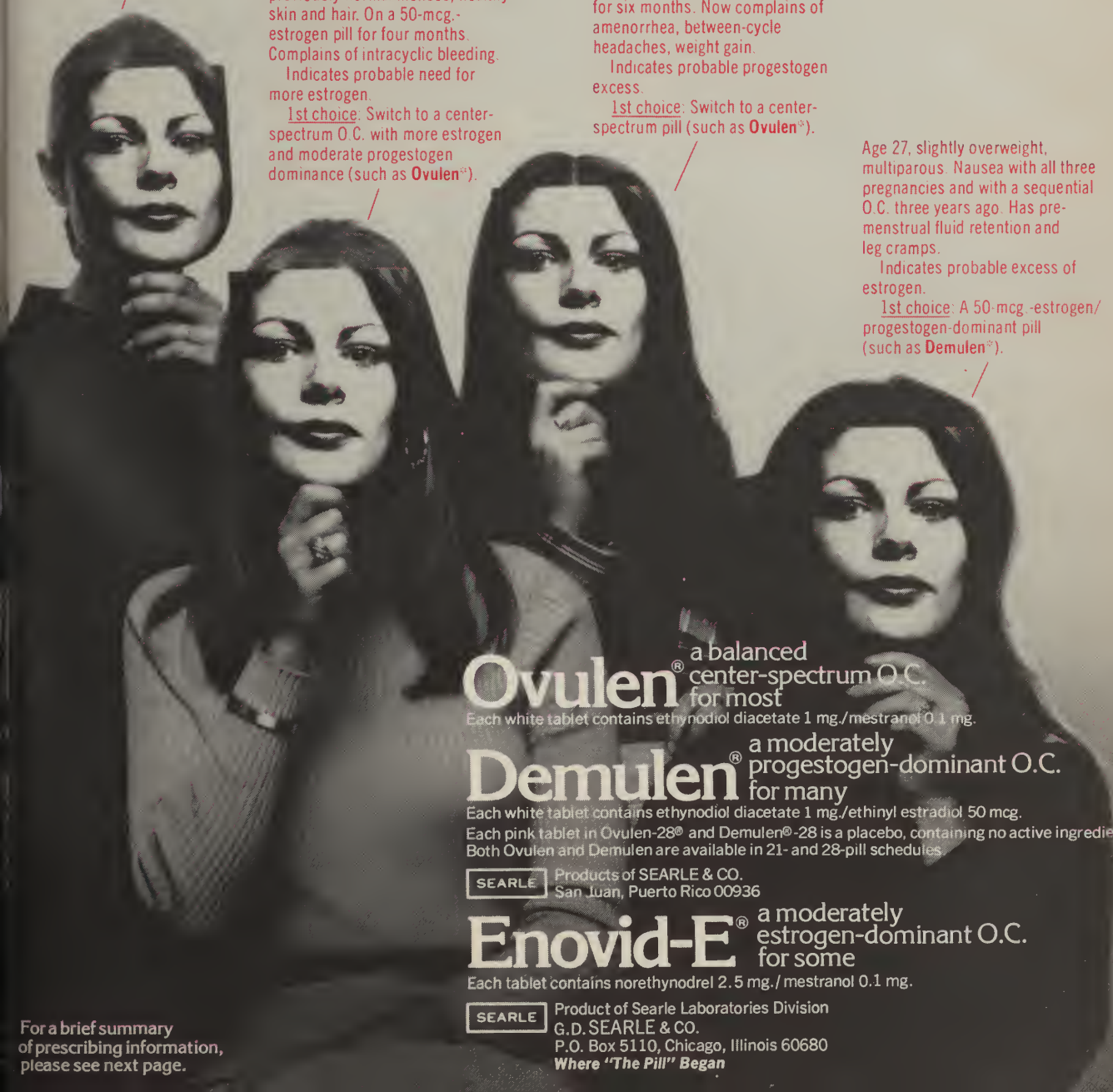
Indicates probable progestogen excess.

1st choice: Switch to a center-spectrum pill (such as **Ovulen***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has pre-menstrual fluid retention and leg cramps.

Indicates probable excess of estrogen.

1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen***).



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Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

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Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

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# a family of O.C. products to help you match the right pill to the right patient

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Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in $T^3$ uptake values; metyrapone test and pregnanediol determination.

**References: 1.** Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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*—George Sarton, from "The History of Medicine Versus the History of Art"*

# Would it be useful in clinical practice to have government predetermine drugs of choice?

# Opinion

**Results of a survey of physicians:**

13.3%
**Yes, it would be useful.**

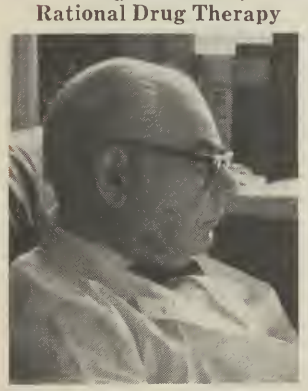
86.7%
**No, it would not be useful.**

# Dialogue

# Would it be useful in clinical practice to have government predetermine drugs of choice?

## Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

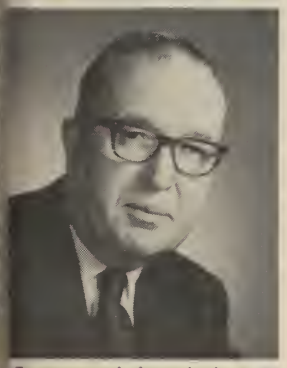
I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really b determined.

The Bureau of Drugs ha suggested the package in sert as a possible means c communicating informatio on relative efficacy of drug to the physician. I find thi objectionable, since I d not believe the physicia should have to rely on thi source for final scientifi truth. There is also a prac tical objection: Since fe physicians actually dis pense drugs, they seldor see the package insert. I any event, I would mair tain that the physicia should know what drug h wants and why without d pending on the governmer or the manufacturer to te him.

Undoubtedly, physician are swamped by excessiv numbers of drugs in som therapeutic categories. An I am well aware that man drugs within such cate gories could be eliminate without any loss, or pe haps even some profit, t the practice of medicin But, in my opinion, neithe the FDA nor any othe single group has the expe tise and the wisdom neces sary to determine the on "drug of choice" in a areas of medical practice.

# Maker of Medicine

enneth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
Eli Lilly and Company



In my opinion, it is not ıe function of any governent or private regulatory ency to designate a "drug choice." This determinaon should be made by the ysician after he has reived full information on ıe properties of a drug, ıd then it will be based on s experience with this ug and his knowledge of ıe individual patient who seeking treatment.

If an evaluation of comırative efficacy were to be ade, particularly by govnment, at the time a new ug is being approved for arketing, it would be a eat disservice to medine and thus to the patient the consumer. For exame, when a new therapeu agent is introduced, on e basis of limited knowlge, it may be considered be more potent, more fective, or safer than oducts already on the arket. Conceivably, at is time the new drug uld be labeled "the drug choice." But as addiınal clinical experience is cumulated, new evidence ay become available. ıter, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin $B_{12}$ as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "*drugs of choice*" is to be avoided.

## Opinion & Dialogue

**What is your opinion, doctor?**
**Send us your comments on the above issue.**

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# ANNUAL REPORTS TO THE HOUSE OF DELEGATES



**HOUSE OF DELEGATES IN SESSION MAY 3, 1972**

*Mr. President and Members of the House of Delegates:*

The following committees or groups held no meetings during the year:

Contractual Arrangements
Maryland State School Health
Medical Annals of Maryland
Reference
Student American Medical Association

## INDEX TO REPORTS OF OFFICERS AND COMMITTEES


Board of Medical Examiners ..... 50
Bylaws ..... 52
Continuing Medical Education ..... 53
Council and Executive Committee ..... 51
Curator ..... 56
Delegates to the AMA ..... 56
Emotional Health ..... 58
Executive Director ..... 56
Finance ..... 59
Hearing and Vision Early Screening ..... 55
Legislative ..... 60
Liaison ..... 60
Library and History Committee, Finney Fund Committee ..... 61
Maryland Blue Shield, Inc., Board of Directors ..... 62
Maryland Medical Political Action ..... 62
Maryland State Medical Journal ..... 63
Mediation ..... 64
Medical Discipline ..... 54
Medical Economics ..... 65
Medicine and Religion ..... 66
Medicolegal ..... 66
Med-Chi Insurance Trust ..... 66
Nominating ..... 67
Occupational and Environmental Health ..... 68
Peer Review ..... 68
Policy and Planning ..... 69
Preventive Medicine and Public Health ..... 69
Professional Medical Services ..... 71
Program and Arrangements ..... 72
Public Relations ..... 72
Secretary ..... 51
Special Committees, New Faculty Building ..... 90
Treasurer (Annual Financial Statements) ..... 73
Woman's Auxiliary ..... 90

## BOARD OF MEDICAL EXAMINERS

*Mr. President and Members of the House of Delegates:*

The Board of Medical Examiners is composed of the following members whose terms expire on the dates indicated below:

| | |
|---|---|
| John E. Adams, MD | 1973 |
| Archie R. Cohen, MD | 1972 |
| DeWitt E. DeLawter, MD | 1973 |
| Gerald A. Galvin, MD | 1975 |
| J. Roy Guyther, MD | 1975 |
| Elmer G. Linhardt, MD | 1974 |
| Karl F. Mech, MD | 1972 |
| John F. Schaefer, MD | 1972 |

As the terms of Archie R. Cohen, MD, and Karl F. Mech, MD, expire June 1972, two members to serve until 1976 are to be elected at the Annual Meeting of the Medical and Chirurgical Faculty, in addition to one member to serve until 1974. John F. Schaefer, MD, was selected by the Board of Medical Examiners of Maryland to serve the unexpired term of William L. Stewart, MD, who resigned on June 21, 1971.

Examinations given during the year show the following results:

| | | |
|---|---|---|
| Applications received for examination | | 435 |
| Second year students examined and reexamined | 0 | |
| Postponed, withdrawn or did not appear | 25 | |
| Not eligible for license | | 25 |
| Examined in second part of examination | 16 | |
| Complete examination | 278 | |
| Reexamined | 102 | |
| Eligible for license | | 410 |
| Passed — American Graduates | 99 | |
| Passed — Foreign Graduates | 111 | |
| Failed — American Graduates | 7 | |
| Failed — Foreign Graduates | 161 | |
| American graduates who failed are as follows: Howard University — 5 Univ. Maryland — 1 Univ. Michigan — 1 | | |
| Licenses issued after examination | | 300 |
| Licenses issued by endorsement of National Board Certificate | | 435 |
| Licenses issued by reciprocity with other state licenses | | 262 |
| Total licenses issued | | 997 |
| Licenses revoked | | 0 |
| Licenses suspended | | 0 |
| Licentiates certified to other states | | 405 |
| Copies of licenses issued | | 8 |
| Foreign graduates approved for examination | | 348 |
| Written inquiries, foreign graduates (approx) | | 2,000 |
| Office interviews, foreign graduates (approx) | | 800 |
| Telephone inquiries, foreign graduates (approx) | | 2,500 |
| Telephone inquiries, registration of physicians | | 5,000 |
| Registration Certificates issued from 1/1/71 to 12/31/71 | | 4,443 |

*Temporary Permit* —It was the decision of the Executive Committee that a Temporary Permit may be issued in the form of a letter, carrying the President's signature and the Board seal. The section of the law is to be quoted, as well as the effective dates.

*Reciprocity After Jan* 1, 1971 — It was proposed that after Jan 1, 1971, the Board of Medical Examiners not endorse out-of-state licenses obtained by passing a written examination taken after Jan 1, 1971, unless that examination was FLEX.

*FLEX Exhibit for Med-Chi Annual Meeting* — This matter was referred to the Board from the Executive Committee for approval to contact the Public Relations Committee of FLEX, to obtain the FLEX Exhibit for presentation at the Annual Meeting of the Medical and Chirurgical Faculty in May 1972.

*Reciprocity with FLEX* — The Board was informed that all states who are not participating in the FLEX program have been contacted regarding reciprocity and endorsement procedures under FLEX.

*Memorandum from Dr. Merchant* — A letter from Dr. Merchant dated Dec 1, 1970, was read in which he notifies the Board regarding endorsement applications referred to the National Board of Medical Examiners from state boards. The National Board is to be regarded as an examining agency with no function in determining the moral character of its diplomates or fitness to practice, other than the completion of educational requirements and successful completion of its examination in accordance with the rules and regulations established by the National Board of Medical Examiners.

*Osteopaths* — A memorandum was received suggesting that the Medical Practice Act be changed this year to provide for reciprocity for Doctors of Osteopathy. It was the opinion of the Board that this may be done, provided the physician is a graduate of an approved Osteopathic College, has completed one year of internship, and has passed the same examination given to graduates of approved medical schools in one of the states or the District of Columbia.

*Commission on Medical Discipline* — The term of Archie R. Cohen, MD, on the Commission on Medical Discipline expires July 1, 1971. He was reappointed to serve through June 30, 1974.

*Hugh St. Clair Geiger, MD* — The Board was informed that the Georgia Board of Medical Examiners revoked the license of Dr. Geiger. Dr. Geiger was found guilty of a crime involving moral turpitude; distribution of intoxicating liquors or drugs for any other than lawful purposes; and the performance of dishonorable, unethical, or unprofessional conduct, likely to deceive, defraud or harm the public. Dr. Geiger was licensed in Maryland on Sep 5, 1952 on the basis of National Board endorsement. He has never registered his Maryland license with this Board. It was the decision of the Board to refer this matter to the Commission on Medical Discipline in accordance with Article 43, Section 121 (10).

*Regulations of the Maryland State Board of Medical Examiners* — A public hearing was held at the offices of the Board of Medical Examiners of Maryland concerning the proposed changes and amendments to the regulations of the Maryland State Board of Medical Examiners "Practice without a license." These changes were adopted by the Board of Medical Examiners of Maryland on Oct 22, 1971, approved by the Secretary of Health and Mental Hygiene of Maryland on Nov 9, 1971 and the effective date of said changes was Nov 9, 1971.

*Continuing Educational Courses* — A letter dated Aug 13, 1971 from Mr. John Sargeant, Executive Director of the Medical and Chirurgical Faculty, concerning continuing educational courses was presented to the Board. The matter was discussed in detail and it was the decision of the Board to unanimously support the proposal to

implement the necessary changes to the Medical Practice Act relating to continuing education.

Respectfully submitted,

ELMER G. LINHARDT, MD, Executive Secretary
JOHN E. ADAMS, MD
ARCHIE R. COHEN, MD
DEWITT E. DELAWTER, MD
GERALD A. GALVIN, MD
J. ROY GUYTHER, MD
KARL F. MECH, MD
JOHN F. SCHAEFER, MD

## SECRETARY

*Mr. President and Members of the House of Delegates:*

In a recent evaluation of Faculty membership it has been learned that our total membership as at the time of the Annual Meeting now exceeds 4,300. This represents a growth over the last ten years as follows:

| | MEMBERSHIP | | |
|---|---|---|---|
| | Active | Other Types | Total |
| 1972 | 3793 | 536 | 4329 |
| 1971 | 3636 | 552 | 4188 |
| 1970 | 3439 | 537 | 3976 |
| 1969 | 3276 | 534 | 3810 |
| 1968 | 3160 | 510 | 3670 |
| 1967 | 3204 | 424 | 3628 |
| 1966 | 3072 | 544 | 3616 |
| 1965 | 2922 | 583 | 3505 |
| 1964 | 2798 | 614 | 3412 |
| 1963 | 2744 | 604 | 3348 |

Increased membership means increased service to the members. This is evidenced by the total number of committee, subcommittee, and other sessions held during the year by various Faculty groups. The Faculty staff has seen to it that work emanating both from and before these meetings has been efficiently executed.

During the past two years, every effort has been made to turn over to the staff of the Baltimore City Medical Society those functions that should properly be performed by it as a component society. Referrals of physicians in the city have been assumed by the city society office; financial activities (maintenance of financial records, etc) have also been assumed by the staff of the Baltimore City Medical Society.

Once again, this report would not be complete if an expression of appreciation were not given to the staff for their dedication to work and for their ever-willingness to answer questions, provide assistance, and to perform over and beyond the call of duty.

Appreciation should also be given to the many members who participate in Executive Committee, Council, and committee meetings. These physicians give of their time and knowledge willingly.

Acknowledgment should also be given to the many physicians who have participated in our physician defense panels; cooperation is excellent; they should have the gratitude of all of our members.

A personal note of gratitude is directed to Mr. John Sargeant whose devotion to the Faculty and knowledge has made the work of the secretary very easy and pleasurable.

Respectfully submitted,

WILLIAM A. PILLSBURY, MD, Secretary

## COUNCIL AND EXECUTIVE COMMITTEE

*Mr. President and Members of the House of Delegates:*

As chairman of the Council, it is my responsibility to account to the House for actions taken by the Council and the Executive Committee between sessions of the House.

There would appear to be some confusion existing in the minds of many members of the Council and the House. In order that some clarification can take place in this regard, let me hasten to say that *the Council acts on behalf of the House* between the annual and semiannual meetings of the House or any special meetings of the House.

As you are aware, on matters of major importance, the Council defers to the House of Delegates, calling special sessions if warranted. The Council may not modify or change any actions taken by the House of Delegates, however.

As the report of the Secretary indicates, the total membership of the Faculty has increased resulting in increases in the total members of the Council and the House. Besides the handling of many routine matters, items of relatively more import discussed in Council and Executive Committee include the following: (All actions are summarized and published regularly in the *Maryland State Medical Journal.*)

June 17, 1971: Adopted a policy in connection with the pronouncement of death which read as follows:

> Unless exceptional circumstances warrant otherwise, it is good medical practice and good medical ethics that a body be identified, viewed and death verified before or at the time of pronouncement of death.

Sept 11, 1971: Authorized publication in the *Maryland State Medical Journal* of the Findings of Fact in cases after they become final and after action taken by the Commission on Medical Discipline.

Sept 11, 1971: Authorized turning over to the Smithsonian Institute on an indefinite loan basis all memorabilia in possession of the Faculty. Appropriate credit will be given the Faculty's ownership whenever material is used in a display.

Nov 11, 1971: Authorized payment of expenses for attendance at AMA House of Delegates sessions of the president and two additional alternate delegates to the AMA House.

Nov 18, 1971: Authorized appointment of a special committee to meet with Blue Shield and discuss these (Medicare) and related problems and clarify them.

Nov 18, 1971: Approved the principle that all physicians participate in a quality-control evaluation of laboratory procedures performed in their offices.

April 13, 1972: Agreed to oppose the transfer of health licensure boards from the Department of Health and Mental Hygiene to the Department of Licensing and Regulation.

May 3, 1972: Nominated the following to Emeritus Membership in the Faculty:

> Emmanuel A. Schimunek, MD
> Jacob M. Miller, MD
> Helen B. Taussig, MD
> James A. McCallum, MD
> James K. Insley, MD

all of Baltimore and

> William S. Murphy, MD, Rockville
> Robert S. Bier, MD, Silver Spring

Respectfully submitted,

MANNING W. ALDEN, MD, Chairman

## BYLAWS COMMITTEE

*Mr. President and Members of the House of Delegates*:

The Bylaws Committee met on Thursday, January 13, and Thursday, March 23, 1972 and proposed the following Bylaw Amendments for your consideration.

1. Amend Article XI, by inserting a new Section 5 to read as follows (all subsequent sections being automatically renumbered) :

| OLD | NEW |
|---|---|
| NONE | Section 5. A COMMITTEE ON EMERGENCY MEDICAL SERVICES composed of those physician representatives of all hospitals in Maryland desiring to participate in this activity shall be appointed by the President who shall also designate the Chairman. This committee shall develop action programs in emergency medical services to meet the state's needs and maintain liaison with groups at all levels concerned with such services. It shall strive for continued improvement in the emergency care provided members of the public; shall develop and present educational programs in this regard; and shall make recommendations in cooperation with other concerned groups and individuals for remedial actions where deemed necessary. It shall also attempt to coordinate, wherever possible, similar activities being carried out by like committees of other organizations. |

The Bylaws Committee has prepared this amendment at the request of the present Subcommittee on Emergency Medical Services currently engaged in these activities. It is deemed important enough that this group be a full standing committee of the Faculty.

2. Amend Article XI, Section 9, by substituting for it the language shown on the right (and automatically renumbering the section for alphabetical arrangement and renumbering as necessary other sections of this article) :

| OLD | NEW |
|---|---|
| Section 9. A LIAISON COMMITTEE of at least ten members shall provide from among its membership such liaison as is required with other professional organizations, such as but not limited to: Maryland Nurses Association, Maryland Pharmaceutical Association, State Department of Health, and specialty medical organizations in the state. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. | Section 18. A COMMITTEE ON JOINT PRACTICES, shall consist of at least five members appointed by the President. This Committee shall meet jointly with representatives of other professional groups and respective licensure boards to discuss areas of mutuality of practice; and to recommend changes in joint practices for the improvement of patient care. It shall make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care with particular attention to the rise of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and paraprofessions in areas long assumed to be the concern solely of the physician and/or the nurse. Health management executives, other professions and allied health personnel, as well as groups involved in health care may be invited to join in planning for optimum working relationships and concerted role performance that will assure the best delivery of quality health care. |

With the rapid development of various allied health manpower disciplines and the necessity for the delegation of duties that have traditionally been performed by physicians, it is important that the profession take leadership in this area. The former subcommittees of the Liaison Committee have been doing this in a small fashion, but the time has now come to have the profession exert its leadership in bringing together all interested persons to better accomplish the delivery of health care to Maryland's citizens.

3. Amend Article XI, Section 17, by inserting the words "at least" between the words "of" and "nine" in the second line of this section and by adding a new paragraph to read as follows: "Any party aggrieved by the action of local Peer Review Committees may, within thirty days of such action, file an appeal in writing with the Peer Review Committee which shall hear the appeal."

OLD

Section 17. The President shall appoint a PEER REVIEW COMMITTEE of nine members, three of whom shall be appointed annually for three-year terms. It shall be the duty of this Committee to advise third party and other agencies as to the appropriateness of medical care rendered by Maryland physicians in institutions and offices or other locations where health care is rendered. It shall develop suitable criteria to adequately evaluate the individual and collective volume, cost and quality of medical care wherever provided. The Committee shall stimulate area hospitals' medical staffs to develop appropriate mechanisms such as utilization committees for review of hospital admissions with respect to need for admission, lengths of stay, discharge practices and evaluation of services ordered and provided. The chairman shall be designated annually by the President.

NEW

Section 17. The President shall appoint a PEER REVIEW COMMITTEE of at least nine members, three of whom shall be appointed annually for three-year terms. It shall be the duty of this Committee to advise third party and other agencies as to the appropriateness of medical care rendered by Maryland physicians in institutions and offices or other locations where health care is rendered. It shall develop suitable criteria to adequately evaluate the individual and collective volume, cost and quality of medical care wherever provided. The Committee shall stimulate area hospitals' medical staffs to develop appropriate mechanisms such as utilization committees for review of hospital admissions with respect to need for admission, lengths of stay, discharge practices and evaluation of services ordered and provided. The chairman shall be designated annually by the President.

Any party aggrieved by the action of local Peer Review Committees may, within thirty days of such action, file an appeal in writing with the Peer Review Committee which shall hear the appeal.

4. The Committee asks unanimous consent that the sections of Article XI on Committees may be secretarially renumbered to arrange them in complete alphabetical order.

5. Amend Article XV by striking out "Robert's Rules of Order Revised" and inserting "the current edition of Robert's Rules of Order, Newly Revised."

OLD

The rules contained in Robert's Rules of Order Revised shall govern the Faculty in all cases to which they are not inconsistent with these bylaws.

NEW

The rules contained in the current edition of Robert's Rules of Order, Newly Revised shall govern the Faculty in all cases to which they are applicable and in which they are not inconsistent with these bylaws.

Respectfully submitted,

CHARLES F. O'DONNELL, MD, Chairman
VINCENT J. FIOCCO, JR., MD
WILLIAM G. SPEED, III, MD
CHARLES VERNON WILLIAMSON, MD

## CONTINUING MEDICAL EDUCATION COMMITTEE

*Mr. President and Members of the House of Delegates:*

Although this committee was authorized by the House of Delegates in May of 1971, it was not appointed until October.

Since that date, the committee has held four meetings primarily devoted to determination of what activities have priority and with which the committee should become involved.

Perhaps the most important action of the committee deals with a request to the American Medical Association for designation of our committee as an accrediting agency for various hospital programs on Continuing Medical Education. At the time of this writing, no final response has been received.

In this connection, appropriate survey forms have been developed and accreditation teams tentatively established. Several such programs are awaiting inspection by our teams, but final action is dependent on approval from the AMA.

The committee has also worked closely with the Regional Medical Program in assessing the medical education needs of physicians in the nonmetropolitan areas of the state. Results of this study will enable all of us to plan better the educational activities of all groups involved.

During the Annual 1972 Meeting, representatives of the AMA's Council on Medical Education will attend the session for the purpose of evaluating our Annual Meeting Program. Preliminary information reveals that a favorable report on our Annual Meeting will be forthcoming.

Recommendations have been made to the Council of the Faculty for approval of a certificate of accreditation which would be distributed to the hospitals whose education programs have been approved. In addition, a recommedation has also been made to the Council that the MEDIC network be discontinued as of July 1, 1972.

In the short time of the committee's existence, much has been accomplished. It is anticipated that more progress will be made and will be reported to the next annual session of the House.

Respectfully submitted,

GERARD CHURCH, MD, Chairman
FREDERICK J. HELDRICH, MD
HENRY R. HERBERT, JR., MD
PHILIP W. HEUMAN, MD
ELMER G. LINHARDT, MD
JOSEPH A. MEAD, MD
ROLAND T. SMOOT, MD
JACK M. ZIMMERMAN, MD

## COMMISSION ON MEDICAL DISCIPLINE

*Mr. President and Members of the House of Delegates:*

The Commission on Medical Discipline is composed of the following members whose terms expire on the dates indicated:

| | |
|---|---|
| Manning W. Alden, MD | 1972 |
| Charles Bagley, III, MD | 1974 |
| Archie R. Cohen, MD | 1974 |
| Jerome Coller, MD | 1974 |
| John M. Dennis, MD | 1972 |
| Elmer G. Linhardt, MD | 1973 |
| Eli M. Lippman, MD | 1972 |
| Karl F. Mech, MD | 1972 |
| John F. Schaefer, MD | 1972 |

Members of the Commission consist of the following persons:

- The President of the Medical and Chirurgical Faculty
- Three members of the Board of Medical Examiners
- The Chairman of the Council of the Medical and Chirurgical Faculty
- Two practicing physicians appointed by the Secretary of Health and Mental Hygiene, from a list of nominees submitted by component societies of the Medical and Chirurgical Faculty
- Two other licensed practicing physicians in Maryland, appointed by the Secretary of Health and Mental Hygiene

### Summary

**Cases Referred to the Commission on Medical Discipline of Maryland Jan 1, 1971-Dec 31, 1971**

20 cases considered by the Commission:

- 4 — violation of narcotic laws
- 5 — professional incompetence
- 4 — unprofessional conduct
- 4 — solicitation and/or advertising
- 2 — illegal abortion
- 1 — license revocation in another state

9 cases pending at this time:

- 3 — violation of narcotic laws
- 1 — professional incompetence
- 3 — unprofessional conduct
- 1 — license revocation in another state
- 1 — illegal abortion

1 license to practice medicine and surgery in Maryland revoked for professional incompetence, willfully making false reports and gross overcharging

1 license to practice medicine and surgery in Maryland suspended for six months for violation of narcotic laws

1 physician placed on probation — solicitation

2 cases closed after reprimand for professional incompetence

6 cases were closed by the Commission and no action taken because of lack of evidence, case dismissed in court:

- 1 — professional incompetence
- 1 — unprofessional conduct
- 3 — solicitation and/or advertising
- 1 — illegal abortion

### Revocation

One case was closed by the Commission following revocation of the physician's license to practice medicine and surgery in Maryland.

*Asuncion L. Palafox, MD*

A formal hearing was conducted in the case of Dr. Palafox who was charged with:

1) Willfully making and filing false reports or records, in your practice as a physician.
2) Willful misrepresentation in treatments.
3) Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services were not rendered.
4) Professional or mental incompetency.

These charges had originated from a complaint from the Utilization Review Department of Blue Cross and Blue Shield. The Peer Review Committee of the Medical and Chirurgical Faculty held a hearing with Dr. Palafox and felt that she was professionally incompetent and that she had been willfully and grossly overcharging. The Commission on Medical Discipline felt that during the hearing that facts had substantiated that she was guilty of 1) willfully making and filing false reports or records in her practice as a physician; 2) gross and willful and continued overcharging for professional services; and 3) professional incompetency, and that she was thus subject to the disciplinary procedures of the Commission. The Commission voted to revoke Dr. Palafox's license to practice medicine and surgery in Maryland.

### Suspension

One case was closed by the Commission following suspension of the physician's license to practice medicine and surgery for six months for violation of the narcotic laws.

*John F. Coolahan, MD*

A formal hearing was held on April 15, 1971 in the case of Dr. Coolahan who had been charged with violation of the narcotic laws. This charge against Dr. Coolahan had arisen after he had been convicted of a similar charge in the Circuit Court of Harford County in August 1969, following which an appeal was denied on Nov 10, 1970. During the hearing Dr. Coolahan admitted writing prescriptions for narcotics without obtaining histories or performing physical examinations because he felt that he was helping narcotic addicts by making it easy for them to obtain narcotics rather than having them committing crimes to do so. The Commission on Medical Discipline found Dr. Coolahan guilty of violating the narcotic laws and suspended his license to practice medicine in Maryland for a six-month period.

Violation of narcotic laws. License suspended for six months effective April 25, 1971. License reinstated Nov 30, 1971.

### Probation

One case was closed by the Commission following probation for solicitation.

*Andrew S. Tegeris, MD*

A formal hearing was held on Sep 2, 1971 and continued on Oct 28, 1971 in the case of Dr. Tegeris who had been charged with 1) solicitation or advertising and 2) division of fees or agreeing to split or divide fees received for professional services. Dr. Tegeris had been investigated in 1970 for advertising but the Commission on Medical

Discipline decided at that time that action on his part was not performed in malice and that he had made an honest mistake. He was warned, at that time, however that additional action of this nature would result in disciplinary procedures. The more recent charges against him resulted from a letter sent to physicians by Dr. Tegeris explaining his fee schedule and suggesting a method of billing for laboratory procedures performed by him resulting in profit for the referring physician. The Commission on Medical Discipline could not substantiate the charge of division of fees etc contrary to Article 43, Section 129 of the Annotated Code of Maryland 1971 Replacement Volume but felt that Dr. Tegeris was guilty of solicitation by suggesting a billing method whereby the referring physician would profit unnecessarily for laboratory work performed by him. Dr. Tegeris was placed on probation for a period of two years and ordered to report to the Commission on Medical Discipline at approximately six-month intervals. Dr. Tegeris has appealed this decision to the Court.

**Reprimand**

Two cases were closed by the Commission following reprimands, both for professional incompetence.

*Harold Harbold, MD*

A formal hearing was held on Sep 9, 1971 in the case concerning two questions which had been raised in the Sellinger Report on the salmonella outbreak at the Gould Convalesarium and which the Commission was asked to investigate by the Attorney General 1) the admission by Dr. Harbold that he had made no substantial attempt to fulfill the duties of a principal physician in a nursing home and 2) that Dr. Harbold absented himself and left on vacation during the salmonella outbreak. Subsequently, Dr. Harbold was charged with 1) abandonment of a patient and 2) professional or mental incompetence. On the basis of testimony before the Commission on Medical Discipline the Commission concluded that Dr. Harbold was guilty of professional incompetence in failing to be aware of his duties while acting as the principal physician of Gould Convalesarium. The charge of abandonment of a patient could not be substantiated. The Commission on Medical Discipline reprimanded Dr. Harbold.

*Jerome Gaber, MD*

A formal hearing was held on Sep 9, 1971 in the case of Dr. Gaber who was charged with 1) willfully making and filing false reports and records in his practice as a physician; 2) of having made willful misrepresentations in treatments; 3) of having grossfully, willfully and continuously overcharged for professional services, including filing of false statements for collection of fees for which services were not rendered; and 4) being professionally or mentally incompetent. These charges were made on the basis of report forms submitted to Blue Shield and a subsequent hearing before the Peer Review Committee of the Medical and Chirurgical Faculty. On the basis of testimony, the Commission on Medical Discipline could not substantiate any of the charges except that of professional incompetency. The Commission on Medical Discipline felt that Dr. Gaber was professionally incompetent on the basis that the quality of the records kept by Dr. Gaber in his practice as a physician prior to an investigation by Blue Shield were substantially below that required by contemporary standards in the local medical community. The Commission further found that the records presently maintained by Dr. Gaber met this standard. The Commission on Medical Discipline reprimanded Dr. Gaber and requested that a Commission member visit Dr. Gaber's office in three to six months and substantiate the fact that Dr. Gaber is abiding by the order set forth by the Commission.

**Closed**

Six cases were closed by the Commission. No action taken.

Respectfully submitted,

JOHN M. DENNIS, MD, Chairman
MANNING W. ALDEN, MD
CHARLES BAGLEY III, MD
ARCHIE R. COHEN, MD
JEROME COLLER, MD
ELMER G. LINHARDT, MD
ELI M. LIPPMAN, MD
KARL F. MECH, MD
JOHN F. SCHAEFFER, MD

## HEARING AND VISION EARLY SCREENING (HAVES)

*Mr. President and Members of the House of Delegates:*

In this second annual report we are pleased to announce considerable progress has been made in the objectives of the program in screening three- and four-year-old children to detect abnormalities in hearing and vision. The validity study for "The Feasibility and Reliability in Using the VASC-Test in Screening" these children for hearing defects is proceeding well. This study, underwritten by Zenith Corporation, is being done by a local PhD in speech and hearing. Upon completion of the study a campaign will be launched to solicit funds from local organizations such as Kiwanis, Rotary, Jaycees, Lions, etc, including a broad spectrum of the public.

A letter of explanation of the program has been sent to several local health officers and component medical societies who, in addition to the Medical and Chirurgical Faculty, are endorsing the screening programs in their areas. Volunteers are being trained to do the hearing screening in conjunction with that for vision, which has been carried on for several years through the auspices of the Maryland Society for the Prevention of Blindness.

The screening clinics, including hearing, were started March 1, 1972; to date 52 have been held for three-year-old children. Four-year-old children have been screened only upon request. Where there has been any question of an abnormality, the child has been rescreened by the audiologist before referral to his family physician, or source of primary medical care, for treatment. The cooperation of physicians in the follow-up on referral patients is requested and needed.

The program has been incorporated, is responsible to the Executive Committee of the Faculty, and has obtained both state and federal tax-exempt status. This is the first such program to be done nationally on three-year-old children; it is anticipated many permanent handicaps will be avoided through early detection. More statistical information should be available next year.

Respectfully submitted,

KARL M. GREEN, MD, President, Board of Trustees
CYRUS L. BLANCHARD, MD
MRS. JANES DAVIS ELLEN
RICHARD E. HOOVER, MD
ARNALL PATZ, MD
MARGARET L. SHERRARD, MD
ALVIN P. WENGER, MD

## CURATOR

*Mr. President and Members of the House of Delegates:*

The Faculty continues to receive items of interest from relatives of deceased physicians, the public, and other interested parties. During the past year the following items have been acknowledged as additions to our collection of memorabilia:

Picture of Dr. Cullen
Miniature of Upton Scott, MD, Founder of the Faculty
Handwritten letter of 1722 or 1772 by William Cullen

As approved by the Council, many of our artifacts have been turned over to the Smithsonian Institution for its History of Medicine Department on an indefinite loan basis. The first display of this material went on exhibit in March 1972.

All of these items have been photographed and appropriately cataloged by the Smithsonian and a copy of these records will be provided the Faculty. We are currently discussing the feasibility of having documents and other items of paper examined by representatives of the Smithsonian for the purpose of their preservation.

Appropriate recognition as to ownership will be provided whenever and wherever items are displayed.

As was done with our artifacts, appropriate recommendations will be made to the Council or House of Delegates when details are worked out.

As has been the custom in the past one or two of our portraits are restored each year. Those most in need of preservation and of greater value than others are chosen by experts in the field. This program, first authorized several years ago, has enabled some 26 portraits to be restored during this period.

Respectfully submitted,

E. DAVID WEINBERG, MD, Curator

## EXECUTIVE DIRECTOR

*Mr. President and Members of the House of Delegates:*

Evidence of the work for which I am responsible to the Council, the House of Delegates, and ultimately to the entire membership is found in the various reports of the committees made both at the annual and semiannual sessions, but also in recommendations to the Council and House.

It is indeed a pleasure to be associated with so many physicians who give of their time and effort without question to make my work that much easier. Too frequently members of the public and the profession take for granted the many free hours of time and expertise that are donated to Faculty affairs. Perhaps I am in the position of seeing this type of selflessness more than the average person, but it is heartwarming to know that so many physician members believe enough in their profession to do this.

The 1972 Annual Meeting marks the completion of 14 years with the Faculty. I have said before and I must repeat it again: despite the many frustrations that occur I do find my work most pleasant, enjoyable, and challenging. A viable organization such as the Faculty does not allow time to sit back and reflect on past accomplishments, but is constantly looking forward to new fields and endeavors with which history will be made.

Respectfully submitted,

JOHN SARGEANT, Executive Director

## DELEGATES TO THE AMA HOUSE OF DELEGATES NOVEMBER 28 — DECEMBER 1, 1971 NEW ORLEANS

*Mr. President and Members of the House of Delegates:*

Your three delegates, two alternate delegates, and the president-elect attended the clinical session of the American Medical Association House of Delegates in New Orleans from November 28 through December 1. A complete summary of the activities and actions of the House of Delegates is provided for the information of Faculty members. As is the custom, all pertinent information has been communicated to the appropriate Faculty committees and officers for their information, advice, and any action at a state level that is considered necessary.

Actions which were not only significant, but historical, were taken by the House of Delegates at the Clinical Convention. They included creation of a special section for medical students, and one for interns and residents; ordering open hearings at the two 1972 conventions to explore questions relating to AMA organizational structure and programs, questions raised by AMA President Wesley W. Hall last June in Atlantic City and again in New Orleans; approving a vote on the Board of Trustees for the AMA vice president; approving participation of nonmembers of the AMA in AMA scientific programs; and directing that the AMA lead in developing a national program for certification of the assistant to the primary care physician.

The House met for a total of nine hours and 42 minutes. It acted on two special reports; 20 reports from the Board of Trustees; eight from the Council on Medical Education; four from the Council on Medical Service; two from the Council on Constitution and Bylaws; and one each from the Judicial Council and Council on Long-Range Planning and Development; plus 72 resolutions.

If one prevailing mood of the House had to be described, it would appear to be one of wanting to move forward, and at the swiftest possible pace.

### Medical Students

No less than five items of business — Report I of the Board of Trustees and four resolutions — concerned this subject, reflecting the intensity of interest. These items were studied by a reference committee and a substitute resolution was offered in lieu of all of them, referring the matter to the Board for study of mechanisms to include students in the organizational structure.

But the House rejected the move. It adopted instead an amended resolution on motion of the California delegation. This measure approved "creation of a special section for medical students and a section for interns and residents." It directed that the Council on Constitution and Bylaws "develop appropriate language to accomplish this purpose," working with representatives of the Student American Medical Association and representatives of the interns and residents. The long-heard appeal of students and younger physicians for a voting voice in the AMA was thus answered.

### President's Address

AMA President Wesley W. Hall said, "Our House of Medicine is sorely in need of some major repairs," and repeated his call for a Constitutional Convention, or other appropriate procedure, for a basic review of organizational structure and programs. He first suggested such a convention upon his inaugauration last June.

Dr. Hall said that since that time he had traveled throughout the nation and heard from physicians "hundreds of unsolicited views on medicine in general, on problems they are encountering in their practice, and on our stewardship of the AMA.

"Frankly, I am troubled and disturbed by what I see and hear," Dr. Hall told the House, "and I am more convinced than ever that we need a basic review of our Association's organizational structure."

He did not envision "a study that will continue over a period of years and years and become bogged down in trying to anticipate problems and programs of the distant future. We all recognize the need for long-range planning, but my concern calls for more immediate action."

Dr. Hall said he was disturbed by a number of things, including losses in membership, association finances, and a decrease in attendance at annual and clinical meetings.

He also said, "We simply have too many programs. Some have outlived their usefulness. Others are of considerable value in these times. Still others should be pruned."

He called for employment of the consulting firm of Cresap, McCormick & Paget, which did a study for the AMA in 1968, to do another survey on AMA operations.

The president also called for closer liaison with specialty societies; suggested the AMA should sponsor only national and international congresses on general subjects, rather than its traditional meetings; and said it may be time to consider reorganizing the association as a "for profit" corporation or service corporation.

●

Dr. Hall's address and Resolution 50, which also called for organizational review, were studied and discussed in reference committee. The committee also studied two reports dealing with the question of a Constitutional Convention, from the Councils on Constitution and Bylaws, and Long-Range Planning and Development, both of which recommended against holding a Constitutional Convention.

The reference committee "reapprised itself of the 1968 management report" of Cresap, McCormick & Paget. Upon completion of Phase I of that study, "the Board of Trustees, of which Dr. Hall was a member, terminated the study and the action was approved by the House of Delegates in December 1969. Your reference committee concurs in this decision."

There is continuous review and evaluation of AMA structure and programs, the committee said.

"Changes in the Constitution and Bylaws at every meeting bear this out. Recent changes in membership provisions with respect to interns and residents, as well as current changes in the status of medical students and voting powers of the vice president, are prime examples."

The committee said the Council on Long-Range Planning and Development was an appropriate mechanism for reviewing structure and programs, and to serve as a focal point for planning activities.

The panel said it believed the Board of Trustees was "vigorously pursuing" the problem with membership and that the President's concern about AMA involvement in scientific matters "will be alleviated by recent changes in the Constitution and Bylaws establishing Section Councils which will become operative in 1972."

Many of the problems faced by medicine come from social unrest and are common to all society, the committee said. It said Dr. Hall, "in his tireless efforts in appearances throughout the country has seen this unrest and is to be commended for bringing this to the attention of the House of Delegates."

The House accepted the committee's recommendation to refer Dr. Hall's remarks and Resolution 50 to the Council on Long-Range Planning and Development. But it also called for specific procedures to be instituted by the Council.

This came in an amendment from the Wisconsin delegation, whose spokesman said it came to the convention "with a mandate to seek a Constitutional Convention or some type of meeting to effect organizational changes." The amendment instructed the Council to hold open hearings for the membership in San Francisco in June 1972 and in Cincinnati in November 1972, and provide the House with progress reports and a summary report on its recommendations and findings in June 1973 in New York.

### Vice President

There was overwhelming support for Resolution 55, to give the vice president of the AMA voting privileges on the Board of Trustees, and the measure was quickly adopted by the House. Presently, the vice president attends Board meetings, with the right of discussion but no vote. The action would increase the size of the Board from 15 to 16 members. Although the House vote had the effect of amending the Bylaws, a constitutional change is necessary, and the matter was referred to the Council on Constitution and Bylaws. Even as discussion continued before the House, the Council came up with the necessary proposed amendments, clearing the way for final action in the annual meeting in June 1972.

### Nonmember Participation

The House amended the Bylaws to permit those physicians who are not members of the AMA to participate in AMA scientific programs as "invited guests." The recommendation came from the Board of Trustees, which said the programs should be available to all members of the profession. The Board report said "nonmember physicians, eminent persons from foreign countries, and residents of the United States who are not engaged in the practice of medicine" may be invited to participate.

### Intern and Resident Dues

The House established annual dues of $20 for interns and residents as AMA members. The amount was calculated "solely to cover some of the costs of the benefits of membership," such as receiving AMA publications. Interns and residents currently may join the AMA in two ways: through active membership in a state association or, where there are no provisions for such membership, by direct application to the AMA. In either case, they must pay the $20 AMA dues.

### Physicians' Assistants

Several major actions were taken in regard to the rapidly developing field of physicians' assistants.

The House directed that the AMA, through its Council on Health Manpower, "assume a leadership role in developing and sponsoring a national program for certification of the assistant to the primary care physician, who functions at the highest level of responsibility described by the National Academy of Sciences as a 'Type A' assistant."

Delegates also adopted a report of the Council on Medical Education, outlining essential requirements for AMA approval of educational programs for such assistants. The essentials were developed in collaboration

with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Society of Internal Medicine.

Essentials of an approved educational program for urologic physicians' assistants, outlined in another Council report, went back to the Council for further study.

The House directed the Board of Trustees to develop guidelines on compensation of physicians for the services of their assistants, and to report back to the House next June.

### Hospital Costs—Education Factors

The rising costs of hospital care, and those cost factors attributable to hospital-based education programs, also drew House attention and action. Delegates adopted a resolution which reiterated AMA concern about increasing costs and pledged AMA efforts to achieve cost control, and added:

*"Resolved,* that the Board of Trustees be urged to assign to appropriate councils and committees the responsibility to conduct a detailed study of the costs of hospital services to identify 1) the multiple factors involved; 2) the elements that have the greatest impact on the rise in hospital costs; 3) the various cost factors attributable to hospital-based medical and allied health education programs; 4) the alternative mechanisms to finance the costs of such educational programs, including the possibility of reducing or eliminating charges to patients that are attributable to such programs; 5) and the degree of impact, if any, that federally funded health programs have on these hospital costs."

The resolution called for the study to be conducted in consultation with the American Hospital Association, private and governmental payment agencies, and representatives of the public. Periodic progress reports, to be submitted at each session of the House of Delegates until completion of the study, also were requested.

### Miscellaneous

Immediate action to improve the quality of emergency medical services in the United States was urged in a Board of Trustees report adopted by the House. The report said:

"Those medical societies that have not already done so are urged to establish councils on emergency medical services or to assign that subject area to an appropriate existing council, whose responsibility should include developing action programs in emergency medical services to meet their area's needs and maintaining liaison with groups at all levels of organized medicine concerned with emergency medical services."

Small communities without necessary resources to develop their own systems "should consider linking together with surrounding communities to form a regional system." Skilled personnel and high quality equipment and facilities should be provided, the report said, and the medical profession should see to it that quality of service is periodically evaluated. The report also recommended a single agency at the federal level with responsibility for all governmental efforts to improve emergency medical services.

A revised statement on the scope, objectives, and functions of occupational health programs also was adopted by the House. The statement said, among other things; "Some employes on occasion may find it impossible to locate or to obtain the services of a personal physician or health service. In such circumstances, limited to where treatment is otherwise unavailable, the occupational physician may undertake additional and continuing treatment of an employe's nonoccupational condition if requested to do so by the employe or his family."

The statement added that if such services become ongoing within the occupational health program, approval of the employer should be obtained. "In order to assure high quality medical care, consideration and approval by the local medical society in developing such projects, including the methods of payment for services, is urged."

The House adopted a study on Community Health Delivery Programs and urged it be given wide distribution. The study, by a task force of the Committee on Community Health Care, described funding, scope of operations, and staffing of 30 programs around the nation.

Physicians should be active, the report recommended, in a number of areas including participating in planning and operation of community health programs; using all means at their disposal to ensure that all people are afforded equal access to adequate medical and health care; supporting campaigns against factors harmful to health such as lead poisoning, drug abuse and poor housing; and supporting health education programs in schools, homes and the mass media. The federal government should be urged to consolidate all federal health programs under one department and to provide long-range approval and multiple-year funding—rather than annual funding—to help retain top staff, the report said.

Respectfully submitted,

ROBERT vL. CAMPBELL, MD
RUSSELL S. FISHER, MD
CHARLES F. O'DONNELL, MD
WILLIAM CARL EBELING, MD, Alternate
M. McKENDREE BOYER, MD, Senior Alternate

## EMOTIONAL HEALTH COMMITTEE

*Mr. President and Members of the House of Delegates:*

Six meetings of the Committee on Emotional Health were held during the past presidential year. Attendance at most of the sessions was excellent and bears out our policy of holding them as dinner meetings.

The committee, through a mechanism of small groups of members, has under study various items of importance to the community. These include Transportation of the Mentally Ill to State Institutions; Mental Health Services in Adult Correctional Institutions; Hotlines and Their Policies with Respect to Information; Mental Health Services to the Drug Abuser; and Mental Health Services to the Elderly.

An intensive investigation was made of the newly-funded program for geriatrics at Good Samaritan Hospital. This revealed that evaluations are being made of all geriatric patients prior to admission to a state hospital for care. The staff consists of two social workers, two internists, and a psychiatrist consultant. Several hundred referrals have been considered by this group, with some 400 being seen personally. Of this total 25% have been sent to state hospitals, 25% to nursing homes, 10% to general hospitals, and 40% returned to the community. Because of the high mortality rate of the elderly in state hospitals, it is felt this is an excellent method of evaluating the elderly person and ensuring proper medical care is provided.

One of the committee members, James J. Gibbs, MD, attended a meeting in Chicago on Insurance Coverage for Mental Health Conditions. A report was submitted

to the whole committee and received favorable comment. Suffice it to say that this continues to present a problem in education of insurance authorities to the necessity of covering mental illness in insurance plans issued by them. The committee observed that the Faculty's own insurance program for its members does not include this very important coverage. An appropriate letter was sent to the Med-Chi Insurance Trust in this regard.

For some two years now, the committee has urged the Faculty to establish a Committee on Health Care of the Poor. Unfortunately, to date, no action has been taken on this proposal.

Liaison was established and continues with the Faculty's Mediation Committee which has the responsibility of establishing ethical guidelines for the treatment of narcotic and other addicts. An exchange of opinions and support has led to worthwhile conclusions in this regard.

The committee also continues to study the question of Mental Health Services for Children and Adolescents. At present, it is not felt sufficient emphasis is being placed on the provision of quality care in the residential management of juveniles.

Contacts have been made with the Department of Correctional Services for the purpose of providing assistance in improving psychiatric services in the institutions coming within the jurisdiction of this agency.

A meeting was held to discuss difficulties being encountered by the Baltimore City Police Department in implementing the Emergency Admission statute passed by the General Assembly in 1971. To date, nothing had been accomplished to correct the difficulties being encountered in this regard.

The committee also considered the question of psychiatric consultation for the performance of an abortion, no longer required by the Joint Commission on Accreditation of Hospital rules. This issue has been clarified and the Faculty's policy with respect to such a consultation has been modified. The Council also adopted, on recommendation of this committee, suggestion that the Faculty membership place more emphasis on prevention of pregnancy and counseling as compared to abortion on which much stress has been placed.

During the 1972 General Assembly session, representatives of the committee were called on to testify on various bills. The position of the committee and the Faculty remain unchanged inasmuch as it supports the inclusion of payment for psychologists under health insurance only when they are part of the mental health care team.

A bill to establish licensure for "Psychotherapists" was evaluated and an analysis presented to the sponsor. In addition, support was given to legislation that would require by statute health insurers to pay for mental health services.

This report would not be complete without a vote of thanks to the many members, including three residents who are invited to attend committee sessions as guests, for their interest and attention to the problems facing the profession. A vote of thanks also goes to the staff at the Faculty office who efficiently make arrangements for our meetings, prepare material, write the minutes and do all the other things to make for a smoothly-run meeting.

Respectfully submitted,

LOUIS W. TINNIN, MD, Chairman
JOSEPH R. COWEN, MD
WILLIAM N. FITZPATRICK, MD
JAMES J. GIBBS, MD
GERTRUDE GROSS, MD
ERNEST E. HARMON, MD
STEPHEN A. HIRSCH, MD
EXALL L. KIMBRO, JR., MD
WILLIAM MAGRUDER, MD
H. THOMAS UNGER, MD

## FINANCE COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Finance Committee met with an investment counselor of the T. Rowe Price Company and reviewed the Faculty's portfolio of securities. It was a detailed review in which most of the holdings were examined individually to determine their value to the portfolio.

During 1971, the general economy improved and the stock market made a significant recovery. The Faculty portfolio enjoyed an appreciation of 14.8% for the 12 months ended Dec 31, 1971. This compares favorably with the Dow Jones Industrial Average and Standard and Poor's "500" which were up 6.1% and 10.8% respectively in the same period of time.

The Inventory of Portfolio as of Dec 31, 1971 shows the market value of invested capital at $1,221,120.74. The approximate income or earnings of the fund was $37,745.65. The yield on invested capital was 3.7%.

T. Rowe Price predicts that business will continue to recover in 1972. They estimate that corporate profits will be 15% higher than 1971. Interest rates are tending upward.

Dr. Mech informed T. Rowe Price that funds will be needed in the near future from the Coggins Building Fund. These funds will be used to purchase the plot of land that will be the site of a future Faculty building. The counselor requested two or three months notice so that the securities can be liquidated when most advantageous.

The committee discussed an informal request from the Baltimore City Medical Society to include the City's reserve funds in the Faculty Portfolio. This would enable Baltimore City to benefit from the investment counseling of T. Rowe Price. Any component society could avail itself of this arrangement, and would pay its proportionate share of the consulting fee. The committee was not opposed to the idea and notified Baltimore City that they would discuss it further with T. Rowe Price after a formal written request was received from the Baltimore City Medical Society.

The new Grant E. Ward Lectureship Fund will be turned over to T. Rowe Price to be added to the portfolio. Other small funds will also be transferred from savings accounts to be invested in the portfolio.

The matter of refunding dues was discussed. At present, the Bylaws do not provide for refund of dues if a member dies or leaves the Faculty. The committee decided it may not be feasible to have a bylaw provision for dues refunds. There are times when individual circumstances may justify the refund of dues, but these are the exceptions. Dues refunds could be determined on an individual basis as merited by the facts in each case. The committee will consider this further if warranted by further developed information.

Respectfully submitted,

KARL F. MECH, MD, Treasurer, Chairman
M. McKENDREE BOYER, MD
A. C. DICK, MD
E. W. DITTO, JR., MD
THEODORE OSIUS, MD

## LEGISLATIVE COMMITTEE

*Mr. President and Members of the House of Delegates:*

A complete summary of activity of the Legislative Committee was mailed to all members of the Faculty following the conclusion of the General Assembly on April 10, 1972. Since that time, the governor has had several bill-signing sessions and it is anticipated that all of the bills in which the Faculty has an interest will be signed into law.

There has been considerable confusion on the part of the Legislative Committee and the Council regarding the Drug-Substitution bill. Suffice it to say that it is our understanding this will be discussed at the House of Delegates session and a final decision reached as to whether to support or reject this bill in the form adopted by the legislature.

As has been the custom, the number of health-related bills continues to increase at an alarming rate. It would appear this is the most thought about topic by our delegates and senators. Certainly, we know that tremendous interest exists in the provision of health care to the people of Maryland. This centers during the session on why there are not enough primary physicians available to serve these needs. While attempts at explanation are made, it is not sure that the sense or magnitude of the problem is really understood by those asking the questions.

For the past several years, an expanded Legislative Committee consists of a representative from each component society as well as a representative from each statewide specialty society. In addition, individual members are appointed by the chairman.

This report would not be complete without expressing appreciation to the members of the Faculty staff who work many long hours in processing legislative information, discussing items with individual legislators as well as state officials, and rounding up representatives to speak at the hearings scheduled in Annapolis, frequently on short notice.

As has been the custom for many years, First Aid Room services were provided by the Faculty including the salary of the nurse on duty, as well as most of the supplies. Physicians are on call through the Anne Arundel County Medical Society; and a physician of the day is on duty during the last three weeks of the session; this latter through courtesy of the Maryland Academy of Family Physicians. The Anne Arundel General Hospital supplies us with some of the equipment and other supplies used.

Proof of the popularity of this service is that more than 1,488 persons were cared for in 1972, compared to 1,083 the year previous.

Respectfully submitted,

B. MARTIN MIDDLETON, MD, Chairman
MARSHALL DIAMOND, MD
JOHN FENWICK, MD
WATSON P. KIME, MD
STEPHEN K. PADUSSIS, MD
J. MORRIS REESE, MD
ROLAND T. SMOOT, MD
C. C. SPENCER, MD
WILLIAM A. WILLIAMS, MD
ELIHU E. ALLINSON, MD
MRS. PEDRO S. DeBORJA
JOSEPH P. CAPPUCCIO, DDS

## LIAISON COMMITTEE

*Mr. President and Members of the House of Delegates:*

The majority of the work of this committee is performed by the various subcommittees. Nursing Liaison, Nursing Home Liaison, and Pharmacy Liaison.

The following are the reports of these various subcommittees:

### Nursing Liaison Subcommittee

This subcommittee held four meetings during the year. These meetings were primarily devoted to the approval and development of various joint policies to be adopted by both the nursing groups and the Faculty.

These additions or changes to the Nurses Protocol included:

Protocol involving Nurse/Anesthetists

Amendment involving the removal of in-dwelling catheters

Vaginal inspection to perform IUD string checks and to collect specimens for PAP smears and cultures for laboratory tests

Statement on the Extended Role of the Professional Nurse

The subcommittee also discussed at some length the role of the subprofessional in dispensing of medication, as well as a change in the name of the parent committee. This latter item is before the House of Delegates. Also discussed in the subcommittee was the question of use of ambulance personnel in performing duties delegated to them by physicians in order to more promptly and adequately care for persons being transported to hospitals.

A joint statement was reached by the nursing and physician groups with respect to an amendment to the Medical Practice Act that would properly place into the statute adequate controls regarding delegation of duties. This passed the state legislature and is currently awaiting signature by the governor.

### Nursing Home Liaison Subcommittee

The subcommittee sponsored an all-day seminar dealing with nursing home care by physicians. Some 150 persons were in attendance with all aspects of this problem discussed at some length.

The subcommittee adopted and sent for approval to its parent committee Recommended Medical Standards for Skilled Nursing Homes. This was approved by the full Liaison Committee.

Still under consideration within this group is a proposed model contract for a medical director in health facilities other than a hospital.

### Pharmacy Liaison Subcommittee

This subcommittee held two sessions during the past year. The primary items of discussion dealt with the status of antisubstitution legislation and a proposal that would permit substitution of drugs by pharmacists, provided they were equivalent in quality.

Despite opposition to this proposal by the subcommittee, legislation was introduced and finally enacted by the General Assembly.

At the full committee meeting reports were received from the various subcommittees, outlining the above data. In addition, a question was raised with respect to mandatory tuberculin testing of workers who have constant contact with children. It is understood the Deparment of Health and Mental Hygiene has this matter under study and is developing regulations in this regard.

After several years of attempting to obtain consultation with the State Education Deparment with respect to the school bus drivers' examinaion form it was agreed it was

fruitless to pursue this further and it was decided to table this matter.

With the conclusion of the 1972 Annual Meeting, the Liaison Committee is abolished and replaced by the Joint Practices Committee, whose duties have been outlined in a bylaw amendment before the House of Delegates.

Respectfully submitted:

JAMES B. BROOKS, MD, Chairman
VERNON R. CROFT, MD
ROBERT E. FARBER, MD
ROBERT GOLDSTEIN, MD
GEORGE H. GREENSTEIN, MD
PAUL F. GUERIN, MD
JOHN H. HIRSCHFELD, MD
EDWARD O. HUNT, JR., MD
DONALD W. MINTZER, MD
ALBERT T. DAWKINS, MD
H. LEONARD WARRES, MD
JEAN ROSE STIFLER, MD

## LIBRARY AND HISTORY COMMITTEE FINNEY FUND COMMITTEE

*Mr. President and Members of the House of Delegates:*

In 1971 the library was forced to operate without a full-time assistant librarian after Mrs. Pochciol resigned in February for family reasons. A search for a replacement ended in November when Mr. Joseph E. Jensen was employed in this capacity. Mr. Jensen came from Denver where he was employed in the University of Colorado Medical School Library. He is primarily in charge of cataloging and acquisitions.

The staff at the end of 1971 consisted of two full-time professional librarians, one part-time professional librarian, one full-time professional trainee, three part-time clerical assistants, and a varying number of student assistants, usually three.

A special project was made possible through a minigrant from the Regional Medical Program of Maryland in the amount of $2,000 to be completed by Feb 29, 1972. On this grant Mrs. Barbara Zelnik, a professional librarian, was employed in November to review, revise, and update the periodical shelflist so that this library can participate in a union list of serials such as the Medical Center of New York publishes, as well as have an accurate list of holdings for its own use. At the end of the year this project was approximately half completed. This work, however, would only be a beginning on the final product for input into a finished serials holdings list. Mrs. Zelnik and Mr. Lawrence Miner were working on this project at the end of the year and continued into 1972.

The History of Medicine project, sometimes called "The Ash Project," so far has netted $10,000 from the sale of duplicates and out-of-scope materials which have been approved for sale by Mr. Lee Ash, library consultant. Not only has this project enabled us to realize some cash returns for items not needed by this library, but has made available in the stacks enough space to remove all the History of Medicine collection to the fourth stack where it is possible to keep them in a secure area and thereby also made it possible for the journals and general book collection to be shifted.

The History of Medicine collection is being cataloged; the existing shelflist is being revised; and the entire collection has been rearranged, with the Noyes classified titles, the Library of Congress classified titles, and the recent National Library of Medicine classified titles apparing in one arrangement. This greatly improves facility of quick location of any title.

During the year there was a decrease in books acquisitions due to the vacancy in the position of assistant librarian in charge of acquisitions and cataloging. However, after a replacement was secured, this activity increased and with the coming year will show quite an increase in new book titles as well as some periodical subscriptions.

New shelving was added in the "Abstracts Alcove" to accommodate the ever-increasing volumes of Excerpta Medica and Index Medicus. The old wooden section of shelving was moved out to make a divider to separate the cataloging area from the reading room. This has become necessary because of the lack of work space elsewhere and, although we were reluctant to do this, there seemed to be no other solution.

At the last meeting of the Council (1971), the library budget for 1972 was approved and included a full-time circulation assistant to attend the circulation desk and supervise the serials operations, including binding procedures.

In the spring the librarian prepared a tentative estimate for the library building program as envisaged for the next 20 years. This was presented to the Ad Hoc Committee on New Faculty Building April 22, 1971 in a meeting at Sheppard and Enoch Pratt Hospital. Following this meeting she attended a one-day seminar on library planning, "Blueprint for the 70s," sponsored by the New York Chapter, Special Libraries Association, on April 23, 1971 at the Biltmore Hotel, New York City. Other sessions on library planning at the annual meetings of the Medical Library Association and the Special Libraries Association were also attended. At end of the year no definite plans for purchase of land or for building had been confirmed.

### Library Statistics - 1971

| | |
|---|---|
| Circulation | |
| Books | 4,956 |
| Journals | 6,863 |
| Pamphlets and VF | 350 |
| Total | 12,169 |
| Medic tapes and slides | 55 |
| Interlibrary loans charged out | 2,766 |
| Inter-library loans borrowed | 340 |
| Photocopying (pages) | 10,509 |
| Acquisitions | |
| Books added | 372 |
| Bound journals added | 418 |
| Total | 790 |
| Books withdrawn | 353 |
| Bibliographies | 361 |
| Gifts | 424 |
| Telephone calls | 3,853 |
| Attendance | 2,539 |
| Previous total volumes | 95,420 |
| Present total volumes (Dec 71) | 95,857 |

Respectfully submitted,

Library and History Committee

PAUL F. GUERIN, MD, Chairman
H. BERTON McCAULEY, DDS
KATHERINE A. CHAPMAN, MD
ROBERT B. GOLDSTEIN, MD
GEORGE A. MAXWELL, MD
THOMAS C. HILL, MD

Finney Fund Committee

WILLIAM H. M. FINNEY, MD, Chairman
RICHARD G. COBLENTZ, MD
RICHARD W. TeLINDE, MD
RICHARD V. HAUVER, MD
THOMAS G. EDISON, MD

## MARYLAND BLUE SHIELD, INC. BOARD OF DIRECTORS

*Mr. President and Members of the House of Delegates:*

If the mission of Maryland Blue Shield is to assist in bringing together the providers and the consumers of health care, then the year ending Dec 31, 1971 was another successful year.

Success, however, is not achieved without help. To whatever degree the organization has been successful — and there are varying standards that are applied — Blue Shield is deeply indebted to the physicians practicing in the State of Maryland, without whose consideration and cooperation, individually and collectively, it would not have been possible.

Both the number of consumers and the number of providers served by Blue Shield in 1971 showed a continuing increase, as did the number of occasions on which service was provided and the degree to which service was made available.

This is demonstrated by a number of indices:

1) The number of subscribers enrolled in Maryland Blue Shield programs increased by nearly 45,000 to a total of 1,283,000, an increase of 3.6% from the end of 1970. Nationally, membership in all Blue Shield plans increased 2.09%

2) Subscription income increased from $34.8 million in 1970 to $42.0 million in 1971, an increase of more than 20%.

3) The number of services for which payment was made in 1971 totaled more than six million, drastically higher than in 1970, but not statistically comparable because of changes in processing that occurred during the year.

4) The total amount of payments made for services received by Blue Shield subscribers in 1971 was $38.2 million, 27% more than paid in the prior year.

5) The number of Maryland physicians agreeing to accept Blue Shield payments as payment in full under specified conditions increased to 4,183, an increase of 149 from the end of the prior year. This continues to represent about 90% of the physicians in private practice in the state.

6) And the total payments made by Maryland Blue Shield in its capacity as carrier for Part B of Medicare increased from $12.7 million in 1970 to $15.0 million in 1971.

Although it is results that count, and this statistical information quite adequately illustrates the achievements of the year, certain administrative activities deserve note also.

Operating expense remained substantially unchanged from the prior year, being equivalent to about 10.8% of subscription income. However, the total of operating expense and claims payments again exceeded subscription income, by a substantially greater amount than in 1970, and uncommitted reserves were correspondingly reduced by $3.4 million, or about two thirds of the level as of the end of 1970. It is expected, however, that the erosion will be arrested, even if not reversed, in 1971, as a result both of adjustments in merit-rated group subscription rates and of increases in direct payment subscription rates approved by the Insurance Commissioner. The losses that were sustained were largely a result of a continuing increase in utilization by subscribers; even this is, in a sense, encouraging in that it suggests that people are obtaining more needed care.

As to distribution of subscribers among Plan A, Plan B, and Plan C, our program of encouraging conversion to higher level benefit programs continued. Plan A enrollment declined by about 40,000 members, a reduction of nearly 50%, to a point where only 3.5% of enrollment is now accounted for by this Plan. Plan C showed an increase in membership to about 36% of total enrollment, only a slight growth in percentage, but a significant increase in number of subscribers from the prior year. The remainder of enrollment growth and group conversion occurred in Plan B membership and in additional subscriptions to special programs, such as the Student Program and Blue Shield 65.

In the area of Professional Relations, Blue Shield in 1971 accelerated its schedule of seminars for physicians' aides, with the intent of doing more both to acquaint office aides further with claims procedures and to elicit more information as to problems being encountered by them. The ultimate objective was, and is, to expedite claims processing and thereby to expedite payments and improve accuracy. Additionally, in a further effort to enhance communication with physicians and their aides, and to facilitate more direct response to their inquiries and requests, incidental to the move of operating groups into the new building four separate telephone lines were installed to be available only for direct incoming calls from physicians and their assistants. Two of the lines are answered directly in the Blue Shield Claims Department and two in the Medicare B Claims Department.

Most physicians are aware that there has been criticism leveled at Blue Shield and Blue Cross Plans in other states alleging that the Plans' governing bodies have inadequate consumer representation. Our Board of Directors acted independently late in 1971, although only coincidental to such possible criticism, and increased the number of General Public Directors. At the same time it was voted that a director representing the dental profession should be added to the Board also. The newly constituted Board, we feel, strikes a desirable balance of consumer and provider representation.

Finally, the Board of Directors wishes to extend its sincere appreciation to the Medical and Chirurgical Faculty and to component and specialty societies, for their continued interest, their dedication to the resolution of mutual problems and their willing and invaluable assistance. The organization is deeply grateful also to the individual physicians who devoted great time and effort to participation in numerous committee meetings and related activities.

Respectfully submitted,

CHARLES F. O'DONNELL, MD, Chairman

## MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

*Mr. President and Members of the House of Delegates:*

Under the leadership of the previous chairman, George Finney, MD, your PAC membership reached its greatest number of members of its ten-year existence.

Although the growth has been statewide, some districts have increased at a more rapid rate than others. Growth seems to be related to physicians' knowledge of the purpose and significance of the PAC movement.

In October 1971, the MMPAC Board met jointly with the legislative chairmen of the county societies and the legislative chairmen of the women's auxiliaries to the county societies to discuss frankly how each organization

could help the other. This was a most successful and educational program.

In November 1971, 12 members of MMPAC attended the Tenth Birthday Dinner of AMPAC in New Orleans. There were over 1,000 physicians and their wives at the dinner. Maryland's own Vice President Agnew was the speaker for the occasion.

The weekend of March 11-12, 1972 was the annual AMA-AMPAC Public Affairs Workshop held in Washington, DC. Again, your PAC was well represented with 17 members present for a most rewarding program.

On March 28 the MMPAC Board interviewed a number of candidates for congressional seats. It would be helpful to every physician if he could have the opportunity of sitting in on these candidate interviews. In addition to information gained from this program, your MMPAC Board is always grateful for letters and comments from physicians concerning the candidates.

Today, Wednesday, May 3, the highlight of the Maryland Medical Political Action year is a luncheon at the Baltimore Hilton, with William Roy of Kansas as our guest speaker. Representative Roy is one of the four physicians in the US House of Representatives. He is a Democrat and, until his election to Congress, was a practicing obstetrician for 15 years. The subject of his talk is, "Medicine and Legislative Trends as I See Them."

One sad note—our field representative from the American Medical Association to this area for a number of years, Mr. Chad Combs, has left to accept another position. We will sorely miss his guidance. His replacement, Mr. Robert Fry, will be with us today and I hope all of you can meet him.

Your chairman is grateful for the opportunity granted him of serving on the PAC Board and the privilege of giving this report today.

Respectfully submitted,

DeWITT E. DeLAWTER, MD, Chairman

## MARYLAND STATE MEDICAL JOURNAL

*Mr. President and Members of the House of Delegates:*

After sailing through some very rough seas earlier in the year, THE JOURNAL has weathered the storms and is now charting a course through calmer waters.

The major disturbance occurred when the printer went out of business unexpectedly in September. An interim printer was secured — the Boyertown Publishing Company, Boyertown, Pa. With heroic efforts, the October issue went to the post office on the 23rd.

A new managing editor, Mr. L. H. Miles, took over the helm in September when Debby Anderson resigned.

One of his chief goals has been to get THE JOURNAL out on a more regular basis instead of having such wide variances each month. The deadline of the 15th has been met or exceeded each month since November with exception of one month when the printer experienced an unusual press problem.

The Editorial Board held two meetings during the past year: one on Nov 9, 1971; another on March 6, 1972.

The terms of two members (Leon W. Berube, MD, and Edward S. Klohr, Jr., MD) expired Dec 31, 1971. Both accepted three-year reappointments.

During the period the interim printer was printing THE JOURNAL, bids were invited from other printers. Some 18 were reviewed at the November Board meeting. After thoroughly weighing all factors including quality, service, price, and the strengths and weaknesses of each printer, the Board agreed to continue with Boyertown until July.

The subject was re-examined at the March meeting. An attractive bid from a local printer was considered. However, on the basis of established working relationships and accomplishments to date, the Board agreed to continue with Boyertown through December 1972. This will be reviewed at a future Editorial Board meeting.

The phase-out period of 18 months with the Sally Ogden Agency for handling local advertising expired April 30, 1972. During the 18-month period, Ruehl & Company has been servicing new (local) accounts. Their low productivity was reviewed at the March Board meeting and the comptroller was authorized to take the necessary steps to enhance our local advertising revenue, securing a new agent if deemed best.

After full and frank discussions with the Ruehl people, written agreement was reached in mid-March (with a 90-day cancellation clause) whereby they will continue as our local advertising representative, subject to future Board review.

At the November meeting, decision was reached to permit the Maryland Medical Political Action Committee to use THE JOURNAL for a column on a quarterly basis. Based on experience to date and the dropping of "The Month in Washington" column, it was recommended and agreed at the March meeting that coverage be extended to a monthly page. All MMPAC material will continue to have editorial review before being used.

The series of front covers and salutes to Maryland hospitals, begun in November, is receiving favorable comments and is enhancing Faculty relations with Maryland hospitals.

The staff having become a one-man operation, responsibility and costs for the Membership Directory have been divorced from THE JOURNAL.

Although the trend in local advertising has been downward, it is expected that this will now be reversed. National advertising revenue continues to increase. Closer controls are being exercised on content, number of pages, and layout. The end result is that, although THE JOURNAL is not a money-making proposition, it is not in the deficit situation that had existed.

At the present time, there is no shortage of scientific articles, departmental materials, or feature items.

During the past year, special issues have been devoted to Sports Medicine, Drug Abuse, Emergency Medicine, and Transactions. Annual and Semiannual Meeting papers have also been featured.

The press run was increased to 4,850 in April to accommodate increased circulation and interest.

In conclusion, the goals of your editors and Board are to provide an interesting, informative, helpful, well-balanced, attractively-packaged product with regularity each month and at a reasonable cost.

Respectfully submitted,

C. THOMAS FLOTTE, Editor
L. H. MILES, Managing Editor

Editorial Board:

LEON W. BERUBE, MD
WILBER R. ELLIS, JR., MD
EDWARD S. KLOHR, JR., MD
E. T. LISANSKY, MD
EDWARD C. H. SCHMIDT, MD
J. B. ZACHARY, MD

## MEDIATION COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Mediation Committee has, perhaps, one of the greatest responsibilities of all committees charged with duties under the Faculty Bylaws. As a result, it is necessary to meet almost each month for long hours and to dispose of many items that create problems unless handled promptly. During the past year, the committee has, among other things:

1) Approved guidelines for the use of corporate names for professional groups composed of five or more physicians and applied these guidelines to various requests submitted by such groups for names that are not identified by the physicians' names themselves.

2) Approved various notices of availability of professional services, as well as removal and other announcement notices.

3) Adopted various forms for listings in the physicians section of the yellow pages telephone directory.

4) Considered various cases where the ethics of some physicians were in question.

5) Referred several cases to the Commission on Medical Discipline with recommendations for disciplinary actions.

6) Approved guidelines for the use of health service plans in promoting participation in such plans.

7) Discussed with representatives of the two medical schools in the state the procedures involved in screening medical students before graduation for addiction as well as other psychological problems.

(SETTLED)

| Component | Total Complaints | Complainant | Defendant | Mutually | Pending 12/31/71 | No Action | Referred To Med-Chi | Remarks |
|---|---|---|---|---|---|---|---|---|
| Allegany County | 2 | | | 2 | 0 | | | |
| Anne Arundel County | 21 | 1 | 18 | 2 | 0 | | | |
| Baltimore City | 122 | 6 | 73 | 11 | 18 | 7 | | 7 insoluble |
| Baltimore County | 52 | 3 | 36 | 2 | 11 | | | |
| Calvert County | | | | | | | | No Complaints |
| Caroline County | | | | | | | | No Complaints |
| Carroll County | 2 | | | 2 | 0 | | | |
| Cecil County | 1 | | | 1 | 0 | | | |
| Charles County | | | | | | | | No Complaints |
| Dorchester County | | | | | | | | No Complaints |
| Frederick County | 3 | 1 | 2 | | 0 | | | |
| Garrett County | | | | | | | | No Complaints |
| Harford County | | | | | | | | No Complaints |
| Howard County | | | | | | | | No Complaints |
| Kent County | | | | | | | | No Complaints |
| Montgomery County | 76 | 12 | 33 | 23 | 8 | | | |
| Prince George's County | 32 | 2 | 24 | | 5 | | 1 | |
| Queen Anne's County | | | | | | | | No Complaints |
| St. Mary's County | | | | | | | | No Complaints |
| Somerset County | | | | | | | | No Complaints |
| Talbot County | | | | | | | | No Complaints |
| Washington County | 7 | | 7 | | 0 | | | |
| Wicomico County | | | | | | | | No Complaints |
| Worcester County | | | | | | | | No Complaints |
| **TOTAL** | **318** | **25** | **193** | **43** | **42** | **7** | **1** | **7** |

The Faculty considered a total of 32 cases of unethical activity on the part of physicians. Of this total, 19 cases were resolved; 10 cases were referred to the Commission on Medical Discipline; and 3 cases were still pending as of Dec 31, 1971.

8) Adopted a policy with respect to physician ownership of proprietary hospitals.

9) Approved various amendments in Guidelines for Physicians in the Treatment of Narcotic Addicts.

10) Cooperated with the Department of Health and Mental Hygiene in the publication of a Drug Abuse Manual.

11) Discussed with a specialty group various aspects of a particular physician's practice which is currently under study by the committee.

12) Requested the Maryland Psychiatric Society to develop material dealing with the use of aides to provide psychiatric care to patients under the supervision of a qualified psychiatrist.

13) Modified previous policy with respect to a physician being permitted to bill for completion of certain insurance claim forms when this burden becomes onerous.

14) Modified previous policy with respect to a physician charging interest on accounts where the patient requests the physician to wait for payment because the matter is in litigation.

15) Investigated in depth a newspaper article dealing with quotes from certain resident staff at the Johns Hopkins Hospital and its seeming denigration of the private practitioner involved in treatment of a patient.

16) Adopted a policy that it is unethical for a physician to provide medical information to credit reporting companies such as Retail Credit inasmuch as medical data should only be released to physicians, hospitals, or other medical persons or institutions.

17 Modified policy with respect to use of bank credit cards by physicians so that it conforms with current AMA policy in this regard.

A list of complaints handled by the statewide group, as well as local component societies, is included with this report.

A summary of the activity of the Subcommittee on Medical Treatment and Drug Programs was prepared and published in the April 1972 issue of the *Maryland State Medical Journal.* This reflects the extensive activity of this group of which the Faculty can be justly proud.

This report would not be complete without an expression of appreciation to its many members who give of their time for the benefit of the public and the profession. It is arduous and demanding work to sit in judgment on ethical matters such as are considered by the committee. An expression of thanks also goes to the staff who provide the committee with background material, and who do much of the leg work that makes its functioning that much easier for the chairman.

Respectfully submitted,

LOUIS J. KOLODNER, MD, Chairman
KATHERINE H. BORKOVICH, MD
VERNON R. CROFT, MD
ROBERT GOLDSTEIN, MD
HILARY T. O'HERLIHY, MD
ROLAND T. SMOOT, MD
WILLIAM J. SULLIVAN, MD
KENT E. ROBINSON, MD
HENRY C. WELCOME, MD
C. VERNON WILLIAMSON, MD
J. MORRIS REESE, MD
RICHARD D. BAUER, MD
ARTHUR G. SIWINSKI, MD
RUSSELL S. FISHER, MD
HENRY A. BRIELE, MD

## MEDICAL ECONOMICS COMMITTEE

*Mr. President and Members of the House of Delegates:*

The committee held four meetings during the past year. A great deal of time and effort were expended in interviewing Brokers of Record for various insurance carriers who expressed an interest in submitting a bid for the professional liability insurance for members of the Faculty. Serious consideration was given to the AMA proposal for C.N.A. through Marsh and McLennan. However, several shortcomings were found in this program and it has been tabled. Presently, other possibilities are being explored and information to members should be forthcoming shortly. Council has allocated funds for development of such proposals.

A questionnaire was distributed to members concerning their experience with Blue Shield. Returns were compiled and a report made. Since there was some criticism of the content of this questionnaire, it is proposed that it will be followed up to obtain more timely and accurate information.

Meetings have been held with representatives of St. Paul Companies in an effort to establish better relations in the fields of communication, rate structures, and individual member problems. With the opening of a new local St. Paul office and changes in personnel, it is believed that this has been accomplished.

Representatives of the Maryland Hospital Association met with the committee to discuss mutual problems and it was agreed that communication lines between the two organizations would be kept open.

The HEW Commission on Medical Malpractice held open hearings across the country and copies of the Faculty's Professional Liability Report have been given to the commission for its information. Contact has been made by representatives of that commission with the Faculty's legal counsel, and this will be mentioned in the national report.

Legislation was enacted in this session of the General Assembly requiring reporting by insurance carriers of all settlements or awards on professional liability cases. This should enable the Faculty to conduct educational programs, with the additional knowledge gained from these reports.

The usual number of fee reviews were conducted, although the policy has now been established of referring such inquiries to component societies for action.

Several minor matters of dispute between physicians and Blue Shield were considered and resolved.

Plans are being made for a program on Medical Economics at the Semiannual Meeting in September 1972.

Respectfully submitted,

W. KENNETH MANSFIELD, MD, Chairman
ARTHUR BAITCH, MD
GAYLORD L. CLARK, JR., MD
FRED COLE, JR., MD
DAVID T. CRAWFORD, MD
SAMUEL M. M. LUMPKIN, MD
ALFRED S. NORTON, MD
HANS WILHELMSEN, MD
DONALD H. HOBBS, DDS

## MEDICINE AND RELIGION COMMITTEE

*Mr. President and Members of the House of Delegates:*

No formal meetings of the committee were held during the past year. However, the chairman has been active in attending meetings and making contacts with state government. In response to an inquiry from the Secretary of Health and Mental Hygiene as to Faculty interest in a symposium on Ethics and Legal Jurisprudence, the chairman met with representatives of the department and submitted a report of that meeting to the Council. An exploratory meeting was to be called and participants appointed by the secretary to plan such a symposium. However, this has not developed to date.

The committee sponsored an exhibit at the Annual Meeting at the Civic Center and Mr. Arne Larson, director of AMA's Department of Medicine and Religion, attended the exhibit.

The chairman attended the Regional Workshop for State Chairmen of Committees on Medicine and Religion in New York City.

Respectfully submitted,

ARCHIE R. COHEN, MD, Chairman
ROBERT W. FARR, MD
CLAUDE D. HILL, MD
REV. WALTER T. GOUCH
REV. CARROLL R. GUNKEL

## MEDICOLEGAL COMMITTEE

*Mr. President and Members of the House of Delegates:*

As usual, most of the work of this committee is done through its subcommittees. The main committee held two meetings; the Subcommittee on Interprofessional Relations held three meetings; and the Symposium Subcommittee two meetings.

Difficulties with commercial insurance carriers, Liberty Mutual in particular, are still being encountered; ie, physicians claim they are told they may not submit medical reports to attorneys of patients. Although correspondence from Liberty Mutual denies such statements, personal contact will be made by the chairman of the subcommittee in an effort to resolve this problem of long standing with a minimum of hard feeling.

The Assignment and Authorization Form designed and approved by the Medicolegal Committee has not been approved by the bar association. However, approval of the Faculty's Council will be requested, after which the form will be made available to physicians at their request.

The Subcommittee on Interprofessional Relations studied and adjudicated the usual number of disputes between attorneys and physicians concerning difficulty in obtaining medical reports, or difficulty in obtaining payment for same. It was agreed that the Medicolegal Code of Cooperation should be clarified in certain areas, defining "treating" and "consulting" physicians, and clarifying responsibility for payment to physicians for medical treatment, medical reports, and court appearances as factual or expert witnesses.

A consultant to HEW's Commission on Medical Malpractice attended a meeting of this subcommittee to express her concern for the direction hearings by the commission are taking. The subcommittee heard this representative with great interest and suggested to the Faculty's Medical Economics Committee further exploration of the information available.

The Symposium Subcommittee sponsored two symposia during the year. The first was held in January 1972 at the Baltimore City Court House. Two physicians debated the question, "Should Marijuana be Legalized?" This was followed by a panel discussion of drugs from several viewpoints. During the Faculty's Annual Meeting in May 1972, the attorneys held a panel discussion entitled "The Doctor's (Legal) Dilemma — Present and Future." While attendance at these symposia has not been as great as the committee would like, it is felt that they serve a useful purpose and should be continued.

Respectfully submitted,

HOWARD F. KINNAMON, MD, Chairman
STUART H. BRAGER, MD
W. BOWDOIN DAVIS, MD
CLINTON R. HARRISON, MD
ARTHUR R. JASION, MD
JOHN DOUGLAS LeBOUVIER, MD
RICHARD J. OTENASEK, JR., MD
LAWRENCE L. PACKER, MD
JONAS R. RAPPEPORT, MD
EDWIN F. RUZICKA, MD
JOHN F. STRAHAN, MD
HERBERT E. WILGIS, MD
JAMES H. COOK, Esq.
BARBARA PRICE DAY, Esq.
WILLIAM G. KEMP, Esq.
JOHN F. KING, Esq.
E. THOMAS MAXWELL, Jr., Esq.
ARTHUR G. MURPHY, Sr., Esq.
RICHARD S. PAULSON, Esq.
CONSTANCE K. PUTZEL, Esq.
HONORABLE STEVEN V. SKLAR
ERNEST M. THOMPSON, Esq.
RODNEY McN. WATTS, Esq.
HONORABLE JAMES L. WRAY

## MED-CHI INSURANCE TRUST

*Mr. President and Members of the House of Delegates:*

It has been another busy year for the Med-Chi Insurance Trust. Every program of the Trust has grown in participation. Many new members have subscribed to the programs and many more members have increased or changed their coverages to avail themselves of the improvements that were incorporated in the plans.

The programs now available to Faculty members through the Trust are:

1) Accident and Sickness Disability Insurance
2) Major Medical Expense Insurance
3) Blue Cross and Blue Shield
4) Business Expense Disability Insurance
5) Level Term Life Insurance
6) Decreasing Term Life Insurance
7) Keogh Retirement Plan

The Accident and Sickness and Major Medical programs underwritten by the Hartford Accident and Indemnity Company experienced an active year. The many improvements made effective in 1971 made these policies among the very best available. The benefits will be even more liberalized if increased participation continues and the

experience remains favorable. During 1971, 118 new policies were issued. In addition, 56 participants increased their coverage under the plan.

Medical assistants of Faculty members are also eligible for coverage in the Hartford plans. At the end of 1971, there were 70 assistants covered.

The Blue Cross and Blue Shield Group is a 70-day plan with Diagnostic III coverage. Medical assistants of Faculty members may participate in the group. The rates of our plan are competitive with other groups, so that it is advantageous to most members to belong to the Faculty plan.

The Business Expense Disability program underwritten by the St. Paul Company has increased its number of subscribers. There were 69 new applicants and increased coverages during 1971.

The Life Insurance program underwritten by the Minnesota Mutual Life Insurance Company has been improved. The limit of coverage has been raised from $20,000 to $50,000, and the rates have been reduced. In 1972, each participant will enjoy a dividend of 12% of the annual premium. Each participant will have the option of receiving a check or applying the dividend to the insurance premium.

The Decreasing Term Life Insurance program underwritten by the Occidental Life Insurance Company is available to members who wish to supplement their other life policies. Although, it has not been offered for an entire year, response has been good. Many applications have been received and are being processed. This plan has many benefits not found in other policies, including a conversion privilege.

The Med-Chi Members Retirement Plan continued to grow in 1971. As of the end of the year 1971, there were 662 participants in the plan. The Equity Fund of the plan at year end totaled $3,126,000. The unit value was $1.57. The fund has increased 26.4% over the 12 months ended Dec 31, 1971. The increase since the plan inception (Jan 1, 1968) is 57%.

The Financial Statement of the Med-Chi Insurance Trust for the year ended Dec 31, 1971 can be found in the Treasurer's audited reports located elsewhere in this publication.

The Med-Chi Insurance Trustees are happy to report this successful year of operation. We are studying the feasibility of new plans to offer the members, while continually striving to improve the existing programs. All of the programs are financially sound and economically advantageous to the members. The continued enthusiastic support of the members will ensure our future success.

Respectfully submitted,

PAUL F. GUERIN, MD, Chairman
HARRY J. CONNOLLY, MD
WILLIAM J. McCLAFFERTY, MD
RICHARD F. MOSCHELL, MD
ALFRED S. NORTON, MD
RICHARD A. YOUNG, MD

## NOMINATING COMMITTEE

*Mr. President and Members of the House of Delegates:*

The following names are being presented for your consideration for election to office. Those elected will assume office at the conclusion of the 1973 Annual Meeting, unless otherwise indicated.

*President-elect*
William Carl Ebeling, MD, Towson
(President-elect 1972-73
(President 1973-74

*First Vice President*
Carolyn H. S. Pincock, MD, Silver Spring (1974)

*Second Vice President*
Manning W. Alden, MD, Annapolis (1974)

*Third Vice President*
William G. Speed, III, MD, Baltimore (1974)

*Secretary*
William A. Pillsbury, MD, Timonium (1974)

*Treasurer*
Karl F. Mech, MD, Baltimore (1974)

*Councilors*

*Central District*
Robert B. Goldstein, MD, Baltimore (1976)
D. Frank Kaltreider, MD, Baltimore (1976)
Donald J. Roop, MD, Towson (1976)
John O. Sharrett, MD, Baltimore (1976)
Philip F. Wagley, MD, Baltimore (1976)

*Eastern District*
Arthur T. Keefe, Jr., MD, Chestertown (1976)

*South Central District*
Charles H. Ligon, MD, Sandy Spring (1976)
Marvin I. Mones, MD, Silver Spring (1976)
Carolyn H. S. Pincock, MD, Silver Spring (1972-73)

*Delegate to the American Medical Association*
Russell S. Fisher, MD, Baltimore
(Jan 1, 1973 — Dec 31, 1975)

*Alternate Delegate to the American Medical Association*
M. McKendree Boyer, MD, Damascus
(Jan 1, 1973 — Dec 31, 1975)

*Committee on Program and Arrangements*
T. Joseph Touhey, MD, Baltimore (1972-76)
Laurence R. Gallager, MD, Columbia (1973-77)

*Library and History Committee*
Roland T. Smoot, MD, Baltimore (1973-78)

*Finney Fund Committee*
James P. McCarrick, MD, Rockville (1973-78)

*Board of Medical Examiners*
Archie R. Cohen, MD, Clear Spring
(June 1972-June 1976)
Karl F. Mech, MD, Baltimore
(June 1972-June 1976)
John F. Schaefer, MD, Baltimore
(June 1972-June 1974)

Respectfully submitted,

HENRY A. BRIELE, MD
Salisbury, Chairman

VINCENT J. FIOCCO, JR., MD
Westminster, Western District

C. GOTTFRIED BAUMANN, MD
Chestertown, Eastern District

CHARLES F. O'DONNELL, MD
Towson, Central District

VERNON R. CROFT, MD
Columbia, Southern District

ROBERT G. ANGLE, MD
Bethesda, South Central District

JOHN M. DENNIS, MD
Baltimore, Member-at-large

## OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE

*Mr. President and Members of the House of Delegates:*

Three meetings of the committee were held this year. Nomination was made to the Governor's Committee for Employment of the Handicapped which was not accepted, however. This brought about discussion concerning the method of selection and this will be followed up in the coming year with the governor's committee.

Responses to the questionnaire sent to physicians concerning their interest in industrial medicine were collated and charted. Representatives of the Chamber of Commerce were invited twice to meet with the committee in order to acquaint them with the availability of physicians for industrial work, and to assist them in implementing the Federal Occupational and Health Safety Act. However, no response was received and this effort to be of service to the community has fallen on deaf ears.

Since it has been decided that a page of the *Maryland State Medical Journal* would be devoted to occupational health every other month, assignments were given to members of the committee.

Plans were initiated for a symposium to be held either late in 1972 or during the 1973 Annual Meeting, on subjects of interest to industrial and occupational health physicians. The Workmen's Compensation Commission will be invited to participate in such a symposium or seminar.

Bylaw charge to this committee is being reviewed and probably a request will be submitted to Council to limit its responsibility to occupational health which includes the working environment, but should not include air, water, and noise pollution in general.

A review of Faculty library books pertaining to occupational, industrial, and preventive medicine will be made to determine whether suggestions might be made for new acquisitions.

Respectfully submitted,

CARLOS VILLAFANA, MD, Chairman
ROBERT BRANDT, MD
WALTER E. FLEISCHER, MD
JAMES FRENKIL, MD
HERMAN J. HALPERIN, MD
WILLIAM J. McCLAFFERTY, MD
DONALD J. ROOP, MD

## PEER REVIEW COMMITTEE

*Mr. President and Members of the House of Delegates:*

The Peer Review Committee has met at least once a month during the past year, not even suspending meetings during the summer. Evolution has provided the committee with its present system of referring many cases to the local level where they can be disposed of. Original jurisdiction is still retained, however, so as to provide uniformity in the decision making process.

To accomplish this, a Bylaw amendment has been introduced into the House of Delegates, through the Bylaws Committee, that would permit either the physician, patient, or third-party carrier to appeal decisions reached on a local level. Carriers are still urged to submit cases for review to the state committee, which can then keep a record of activity taking place in this important area involving the practice of medicine.

Despite handling a large number of cases on a state level, there is still a backlog of cases pending review at the time of the Annual Meeting.

The committee was asked to present a program on Peer Review as part of the annual scientific session. This has been arranged and it is hoped will attract a large number of physicians. It is only through this and other mechanisms that the main purpose of peer review can be attained—education.

As can be understood, the committee is still cutting its teeth on many vexatious problems. It has been asked to appear as witnesses should a third-party carrier become involved in a court case concerning denial of benefits based, in part, on a decision of the committee. Legal counsel has determined that this should not be done and the carrier has been so advised.

The committee recommended to the Council and the Council adopted a policy recommending evaluation of laboratory services provided in physicians' offices for their own patients. It is understood that Blue Shield will eventually require participation in such an evaluation program in order for a physician to be paid for diagnostic laboratory tests under the various diagnostic programs.

As authorized by the semiannual meeting of the House of Delegates, steps have been taken toward the establishment of the Maryland Foundation for Health Care. Bylaws have been adopted and, at present, incorporation papers are being drafted by legal counsel.

Close cooperation has been maintained with various statewide specialty groups and cases have been referred to them when the situation warranted such referrals. The Maryland Society of Internal Medicine has been particularly helpful in this regard.

Some physicians have been referred to the Commission on Medical Discipline for disciplinary proceedings as a result of the committee's deliberations. This is not the general rule, however.

A summary of cases reviewed since the inception of the committee is presented as follows:

| | |
|---|---|
| Total cases closed | 32 |
| Total cases pending | 10 |
| Total new cases | 9 |

This report would not be complete without an expression of appreciation to the members of the committee who give freely of their time to tackle vexatious and sometimes frustrating problems. The only satisfaction received is the sense that improvements in the quality of medical care are taking place.

### Future Activities

1) Promote peer review in effort to raise quality of health care delivery in the State of Maryland. This requires continuing emphasis to the membership and consumer.

2) Continue development of local and specialty peer review.

3) Promote and establish a foundation whose prime function will be that of audit.

Respectfully submitted,

ARTHUR E. COCCO, MD, Chairman
RICHARD C. ARBOGAST, MD
KATHERINE H. BORKOVICH, MD
EARL C. CLAY, JR., MD
JOHN R. DAVIS, MD
LEEDS E. KATZEN, MD
WATSON P. KIME, MD
HARRY F. KLINEFELTER, MD
CHARLES H. LIGON, MD
JOHN G. WISWELL, MD

## POLICY AND PLANNING COMMITTEE

*Mr. President and Members of the House of Delegates:*

Your Committee met on several occasions to discuss Resolution 1A/71, referred to it by the House of Delegates in May of 1971. The Committee wishes to offer the following substitute resolution and recommends its adoption by the House of Delegates:*

WHEREAS, In 1962, as a result of a Professional Management Study, the Faculty considered the question of hiring a Professional Negotiator; and

WHEREAS, Many convincing arguments were presented at that time for the Faculty to take such action, including:

a) Negotiation is a highly skilled art requiring special knowledge and training;

b) The Government and other parties are always represented by a Professional Negotiator;

c) Medical and Chirurgical Faculty, in the past, has been represented by committees of physicians, who, by and large, are untrained in negotiating skills;

d) The committees change from time to time preventing any real continuity on a year-to-year basis;

e) It will provide a consensus for the profession, whereas decisions are sometimes not reached for the benefit of the majority;

f) Such a negotiator would know the appropriate time to reach a compromise in the best interests of the public;

g) Continued contact with persons "on the other side" would make negotiation easier and more constructive;

and

WHEREAS, These arguments are still valid and, perhaps more so, because of the increasing number of prepayment mechanisms that are coming into play; and

WHEREAS, An increasing amount of assistance must be provided to members of the Medical and Chirurgical Faculty to help:

a) Design means of case appeals when legal action is necessary;

b) Be a representative for the profession in situations requiring arbitration or where the potential exists for limiting, controlling, negating, or abolishing professional rights;

c) Attend to specific areas of differences with negotiations involving third-party insurance carriers, Phase II of federal governmental price controls (or any successor thereto); as well as to provide interpretations of governmental regulations;

d) Collate data regarding legal and regulatory governmental controls on medicine (eg, keeping abreast of changes in the Medicare law, as well as tracing the authority for such regulations or directives as well as the interpretations of such items by third-party carriers);

e) At request of individual members of the Faculty prepare or produce data for concise, logical presentation of a claim or complaint and intercede on his behalf as needed; and

WHEREAS, Such a person could perform other collateral duties as required or needed in areas such as determination of legality of ethical decisions of the Faculty, provision of legal opinions regarding problems physicians encounter in their practice, drafting of legislation and interpretation of bills before the General Assembly; and

WHEREAS, Such an individual should demonstrate enthusiasm and originality in addition to having a loyalty to the medical profession; should have a fresh innovative approach, which would be a premium characteristic; should be provided with sufficient remuneration so that his interest and loyalty might not be divided; therefore be it

*Resolved,* That the Council of the Medical and Chirurgical Faculty of the State of Maryland be directed to seek out and employ a qualified (negotiator) *Legal Counsel* in whose charge would be placed the responsibility for dealing with third-party payment mechanisms under the policy direction of an appropriate committee; and be it further

*Resolved,* That the duties and responsibilities of such an individual include other related socioeconomic matters deemed appropriate by the Council.

* *Italics indicate new matter. Brackets indicate stricken matter.*

Respectfully submitted,

ARTHUR T. KEEFE, JR., MD, Chairman
JOHN F. SCHAEFER, MD
DeWITT E. DeLAWTER, MD
WILLIAM A. PILLSBURY, MD
KARL F. MECH, MD
MANNING W. ALDEN, MD
JOHN M. DENNIS, MD
EARL CAMPBELL, MD, Allegany County
JULIUS LOEBL, MD, Anne Arundel County
KATHERINE H. BORKOVICH, MD, Baltimore
DONALD J. ROOP, MD, Baltimore County
ISSAM F. EL-DAMALOUJI, MD, Calvert County
HENRY R. TRAPNELL, MD, Caroline County
SHERMAN S. M. CHANG, MD, Carroll County
PIETRO CAPURRO, MD, Cecil County
HENRY L. BURKE, MD, Charles County
F. M. DOMINGUEZ, MD, Dorchester County
RICHARD L. FRUTH, MD, Frederick County
FREDERICK J. HATEM, MD, Harford County
SARAH E. GLOVER, MD, Montgomery County
ROBERT P. DEITZ, MD, Prince George's County
JOHN R. SMITH, MD, Queen Anne's County
J. ROY GUYTHER, MD, St. Mary's County
ROBERT vL. CAMPBELL, MD, Washington County
FRANK E. POOLE, MD, Wicomico County

## PREVENTIVE MEDICINE AND PUBLIC HEALTH COMMITTEE

*Mr. President and Members of the House of Delegates:*

This committee was divided following the annual session of the House in 1971. It is now known by its present name.

Since its inception it has had four meetings at which a variety of subjects have been discussed. The majority of the work is done in the various subcommittees, with the major committee acting on recommendations and proposals from these smaller groups.

The committee was organized into the following subcommittees: Airport Medicine, Alcoholism, Child Welfare, Emergency Medical Services, Human Ecology, Immunization Practices, Maternal Welfare, Medical Aspects of Sports, and Traffic Safety.

The following actions were adopted by the committee during the year:

1) Endorsed the standards for Inhalation Therapy, as promulgated by the Maryland Thoracic Society; and submitted them to the Subcommittee on Human Ecology for review.

2) Reaffirmed its previous action regarding the distribution of validation stamps for foreign travel; ie, that they be made available only to physicians who perform 300 or more such vaccinations a year as these certificates are easily available through local and state health departments.

3) Approved the Subcommittee on Alcoholism acting as a referral agency for physicians who may be dependent on alcohol.

4) Cosponsorship of the Second Annual Meeting of the American Medical Society on Alcoholism held in Baltimore in October 1971.

5) Endorsed the Alcohol Safety Action Project (ASAP) in Maryland.

6) Endorsed the state health department's regulations dealing with day care centers.

7) Endorsed the state health department's regulations dealing with pacifiers.

8) Released a statement on Learning Disabilities of Children.

9) Recommended to Council, which approved the recommendation, that the requirement for smallpox immunization prior to entering school be deleted from the law and that in its place be substituted a statute that would authorize the State Department of Health and Mental Hygiene, in consultation with the Faculty, to list a) those immunizations that would be a requirement for entering a Maryland school; and b) those persons at high risk who would be required to have immunization against smallpox. These proposals were enacted into law by the General Assembly.

10) Mailed a Tetanus Alert and Recommended Schedule of Immunizations and Tuberculin Testing to all Faculty members.

11) Supported the spirit and intent of the proposed air quality control regulations as proposed by the state department of health.

12) Recommended to Dr. Solomon that a member of the Faculty be appointed to the Air Quality Control Advisory Council.

13) Obtained the appointment of three additional members of the Faculty to the State Emergency Advisory Care Council.

14) Recommended to the Council that the Faculty request Blue Cross to give consideration to increasing coverage for normal pregnancies.

The Subcommittee on the Medical Aspects of Sports held its annual seminar on this subject, which continues to draw a large number of participants. It is planned to continue this worthwhile activity. The subcommittee has expressed concern over the establishment of a sports accident registry, so that the extent and scope of injuries resulting from high school and college sports could be evaluated. To date, it has been unsuccessful in doing so.

The Subcommittee on Emergency Medical Services also held a most successful repeat seminar, this year in cooperation with Sinai Hospital. Its excellent attendance augurs well for a continuation of this activity filling a need for education in this area.

The Child Welfare Subcommittee held a statewide meeting on Nov 10, 1971, to discuss the question of regionalized and centralized perinatal intensive care units. There was immense interest in this subject and it is planned to formulate some specific recommendations in this area in the near future.

The Subcommittee on College Health was, unfortunately, not activated this year primarily because of lack of finding a suitable chairman. It is hoped to have this as an ongoing group next year.

A representative of the Emotional Health Committee served on the committee as a liaison member between the two committees.

Respectfully submitted,

Committee on Preventive Medicine and Public Health

ROBERT E. FARBER, MD, Chairman
RUDIGER BREITENECKER, MD
ROBERT L. CAVENAUGH, MD
EDWARD DAVENS, MD
KARL M. GREEN, MD
CLAUDE D. HILL, MD
JOHN H. HIRSCHFELD, MD
D. FRANK KALTREIDER, MD
JULIUS LOEBL, MD
RAYMOND P. SRSIC, MD
JEAN R. STIFLER, MD
RAMSAY B. THOMAS, MD
FRANCIS J. TOWNSEND, JR., MD
LOUIS W. TINNIN, MD
BENJAMIN D. WHITE, MD

Subcommittee on Airport Medicine

JULIUS LOEBL, MD, Chairman
DONALD M. BARRICK, MD
JOHN B. De HOFF, MD
ARIS T. ALLEN, MD
JAMES E. TOHER, MD

Subcommittee on Alcoholism

JOHN H. HIRSCHFELD, MD, Chairman
CONRAD B. ACTON, MD
ARISTIDES C. ALEVIZATOS, MD
EDMUND G. BEACHAM, MD
STANLEY J. BOCIEK, MD
JOHN R. DAVIS, MD
SEANA HIRSCHFELD, MD
ISADORE KAPLAN, MD
HARRY F. KLINEFELTER, MD
LEONARD M. LISTER, MD
ABRAHAM M. SCHNEIDMUHL, MD
ROLAND T. SMOOT, MD
IRVING J. TAYLOR, MD
MAXWELL N. WEISMAN, MD
REV. HARRY E. SHELLEY (Advisory Member)
LUDWIG L. LANKFORD (Advisory Member)

Subcommittee on Child Welfare

RAYMOND P. SRSIC, MD, Chairman
R.M.N. CROSBY, MD
JOHN A. GRANT, MD
WILSON L. GRUBB, MD
MURRAY M. KAPPELMAN, MD
EDWARD J. KOENIGSBERG, MD
JOSEPH J. McDONALD, MD
LAWRENCE C. PAKULA, MD
JOHN L. PITTS, MD
MARGARET L. SHERRARD, MD
BENJAMIN D. WHITE, MD
ROBERT E. YIM, MD

Subcommittee on Human Ecology

ROBERT L. CAVENAUGH, MD, Chairman
FAYE W. ALLEN, MD

NICHOLAS GIARRITTA, MD
MILTON B. KRESS, MD
J. BRETT LAZAR, MD
JOHN E. MILLER, MD
RICHARD L. RILEY, MD
SAMUEL P. SCALIA, MD

Subcommittee on Immunization Practices

KARL M. GREEN, MD, Chairman
CHESTER C. COLLINS, MD
ROBERT E. FARBER, MD
HOWARD J. GARBER, MD
MURRAY M. KAPPELMAN, MD
GEORGE H. MITCHELL, MD
LAWRENCE C. PAKULA, MD
JOHN L. PITTS, MD
MARGARET L. SHERRARD, MD
JOHN STAFFORD, MD
BENJAMIN D. WHITE, MD
ROBERT E. YIM, MD
WAYNE BOBBITT (Advisory Member)

Subcommittee on Maternal Welfare

D. FRANK KALTREIDER, MD, Chairman
MERVYN L. CAREY, MD
GEORGE H. DAVIS, MD
RAFAEL GARCIA-BUNUEL, MD
JOHN S. HAUGHT, MD
HUGH B. McNALLY, MD
HAROLD ROSEN, MD
EDWIN R. RUZICKA, MD
JOHN E. SAVAGE, MD
J. KING B.E. SEEGER, MD
JOHN WHITRIDGE, MD
HERBERT L. YOUSEM, MD

Subcommittee on Medical Aspects of Sports

RAMSAY B. THOMAS, MD, Chairman
JOSEPH ALVAREZ, MD
CHARLES M. HENDERSON, MD
G. OVERTON HIMMELWRIGHT, MD
HERBERT W. LAPP, MD
HERMAN C. MAGANZINI, MD
CLARENCE McWILLIAMS, MD
SHERMAN S. ROBINSON, MD
EDGAR P. WILLIAMSON, MD
JOHN H. KAHNERT, PhD (Advisory Member)
AL MALONE (Advisory Member)
JOHN MANLEY (Advisory Member)
PHILIP H. PUSHKIN, DDS (Advisory Member)

Subcommittee on Traffic Safety

RUDIGER BREITENECKER, MD, Chairman
TIMOTHY D. BAKER, MD
RUTH W. BALDWIN, MD
RAYMOND M. CUNNINGHAM, MD
JOHN B. De HOFF, MD
IRENE L. HITCHMAN, MD
PAUL V. JOLIET, MD
HOWARD F. KINNAMON, MD
ABRAHAM J. MIRKIN, MD
PERRY STEARNS, MD
ROBERT J. WILDER, MD

## PROFESSIONAL MEDICAL SERVICES COMMITTEE

*Mr. President and Members of the House of Delegates:*

The committee held one formal meeting during the year, but divided into three subcommittees for the bulk of its activities. A request for consideration including salaries of full-time physicians in future fee reviews was considered. However, there was considerable misunderstanding as to the purpose of this request and subsequent meetings were held between the chairman and Executive Committee and originator of the request in an effort to resolve these misunderstandings. As a result, agreement was reached that salaried physicians who were not members of the Faculty would be interviewed; statistical data would continue to be collected in connection with remuneration of industrial medicine, consultation fees, etc; AMA delegates be informed of the Faculty's support of the development of a section to provide benefits for full-time physicians who do not benefit from other activities of the AMA; and to survey present full-time, salaried members to solicit information as to needs and offer Faculty assistance in fulfilling those needs.

A suggestion was made that this committee make a study of Health Care for the Poor, emanating from an AMA resolution. Because of difficulty in obtaining the necessary accurate information and in obtaining funds for such a research study, this was referred back to Council for further consideration.

A Medicaid program requirement for certification of accuracy of information on Medicaid billing forms under threat of prosecution evoked much criticism. The form was carefully studied and suggestions made to the Department of Health and Mental Hygiene for its revision and advice to members as to its legal implications.

The committee's most important and most trying problem has been the implementation of the Resolution by the House of Delegates concerning accumulation of fee data for professional services. Meetings were held between your chairman, chairman of the Subcommittee on Collection and Evaluation of Fee Data, and staff personnel in an attempt to put the wheels in motion. It becomes apparent that a survey of the membership, use of computer time as well as computer analysis, print-out of data, and additional personnel needed will run into considerable cost. The full committee will be asked to make a decision as to whether allocation of such funds should be requested of Council.

Respectfully submitted,

MORRIS J. WIZENBERG, MD, Chairman
THEODORE E. STACY, JR., MD
WILLIAM KRESS, DDS
STANLEY N. YAFFEE, MD
SAMUEL M. M. LUMPKIN, MD
JOHN FENWICK, MD
ARTHUR T. HALL, JR., MD
WORTH B. DANIELS, MD
EDWARD M. BARCZAK, MD
JEROME ROSS, MD
THOMAS HUNT, MD
JOHN E. ADAMS, MD
ALBERT J. WEISS, MD
B. STANLEY COHEN, MD
LEX B. SMITH, MD
SALVATORE J. DEMARCO, III, MD
FRANK FARAINO, MD
ROBERT B. GOLDSTEIN, MD
P. W. MERCER, MD
CHARLES EARL HILL, MD
ANDREW C. MITCHELL, MD
FORREST K. HARRIS, II, MD
DONALD W. MINTZER, MD
WILLIAM A. MOSBERG, JR., MD
ROBERT W. JOHNSON, III, MD
ROBERT T. THIBADEAU, MD
WILLIAM A. TYSON, MD
EDWIN H. STEWART, JR., MD

## COMMITTEE ON PROGRAM AND ARRANGEMENTS

*Mr. President and Members of the House of Delegates:*

During the 1971-72 year there were several innovations regarding annual and semiannual meetings. For the first time in the history of the Faculty, a semiannual meeting was held outside the United States — Puerto Rico. A 747 jet airplane was chartered and filled by 350 physicians and their wives. The Auxiliary held its usual meeting, and there were three full days of scientific sessions arranged by members of the committee and a physician from Puerto Rico who is currently at The Johns Hopkins Hospital.

All the speakers were from Puerto Rico, with one exception. The sessions were well attended and the facilities more than adequate at the luxurious El Conquistador. A registration of attendance was taken at each session. There were golf and tennis tournaments and a banquet with excellent local entertainment. The House of Delegates met in the Faculty Building the Saturday prior to the group leaving for Puerto Rico. All in all, this type meeting proved most successful and it is recommended that semiannual meetings be held out of the country from time to time.

The 1972 Annual Meeting also was innovative for the Faculty in that three concurrent scientific sessions were scheduled during two full days, plus one afternoon plenary session. The concurrent sessions were cosponsored by the various specialty societies in Maryland. These sessions were well received with, in many instances, the attendance at the individual concurrent session being higher than the attendance at any of the plenary sessions in previous years.

The total registration was 1,864, of which 912 were physicians. The remainder of the registrants were primarily allied medical personnel, such as nurses and technicians, plus many medical students.

For the first time in several years, the annual Round Table Luncheon was a "sellout," with many favorable comments received regarding the discussions and moderators. The Hospitality Night was a most successful social function. The annual Presidential Reception and Banquet, as always, was well attended and a definite highlight of the meeting. The health evaluation tests were well planned and efficiently performed through the efforts of an industrious subcommittee. The results will be processed by computer by courtesy of the Maryland Blue Cross. The number of scientific exhibits more than doubled those in 1971 and were of excellent quality. The technical exhibit income was slightly higher than last year. The charge was not increased, but there were more exhibitors. The second annual Art & Hobby Exhibit was held and has become a popular addition to the meeting.

Scientific sessions were scheduled for Friday afternoon this year for the first time, but this did not prove satisfactory as the attendance dropped and the exhibitors started to remove the exhibits which caused disturbing noises in the meeting rooms. It has been recommended that next year the Annual Meeting close at 1:00 PM on Friday.

The committee discussed that, in the future, consideration be given to more involvement by the two medical schools in scientific exhibits and programs of the Faculty. The incoming chairman is planning to look into this.

Plans have been completed by the incoming chairman, Albert M. Antlitz, MD, and his committee for the 1972 Semiannual Meeting. The location, the Ocean City Convention Hall, was selected because of many requests that the Faculty hold some of its meetings in that city.

A survey team from the AMA evaluated the Annual Meeting to determine whether the Faculty scientific programs would be accredited. The oral comments of the team were most favorable, but a final report has not yet been received.

On behalf of the committee and the president, I extend sincere thanks to the many Faculty and Auxiliary members for their cooperation and efforts. Special thanks must be given to the members of the Subcommittee on Health Evaluation Tests who gave and are still giving so much of their time and experience to provide this excellent service to their fellow members.

Respectfully submitted,

JOHN B. De HOFF, MD, Chairman
ALBERT M. ANTLITZ, MD
J. DONALD DRINKARD, MD
EDWIN H. STEWART, JR., MD
J. PHILIP NORRIS, DDS
MRS. ROBERT A. REITER

Subcommittee on Exhibits:

ALBERT M. ANTLITZ, MD, Chairman
J. DONALD DRINKARD, MD
RICHARD R. CRANE
GORDON WEHRLE

Subcommittee on Health Evaluation Tests:

FREDERICK W. BAUER, MD, Chairman
VICTOR A. FAZEKAS, MD
D. V. LINDENSTRUTH, MD
JOSEPH J. WITYK, MD
JOHN W. PAYNE, MD
LEONARD H. BERGER, MD
DOROTHY HARTEL

Subcommittee on Art and Hobby Exhibit:

MRS. BERNARD S. GORDON, Chairman
MRS. ROBERT E. CRANLEY, JR., Co-chairman
MRS. MARIUS P. JOHNSON
MRS. DEZSO K. MERENYI

## PUBLIC RELATIONS

*Mr. President and Members of the House of Delegates:*

The Public Relations Committee held three regular committee meetings plus three meetings called by the chairman for special purposes. The main thrust of the committee this year has been toward increasing enrollment in the two Maryland medical schools. For this reason, meetings were held with representatives of Departments of Medical Education at community hospitals and deans of the two medical schools. While some progress was made (vis-a-vis, enrollment at University of Maryland School of Medicine has been increased to 155 one year sooner than anticipated), much is left to be done. Members of the state legislature have been apprised of the situation, and hopefully their influence will be felt through allocation of funds.

In response to the Pharmaceutical Association's designation of VD Awareness Month in August 1971, the committee met with representatives of the Pharmaceutical Association to discuss means of disseminating VD information to school children in the most effective way. Representatives of the school system were also consulted and attended another meeting to further discuss this matter. However, after much study it was decided that the proper role of the Faculty was to act as a catalyst in offering services of physicians in whatever manner the school system desired, since many programs are already being offered. While the media was explored for possible assist-

ance, this was considered to be already overloaded with such programs, and such services will be held in reserve for future use.

The Woman's Auxiliary, in conjunction with this committee, held a theater party benefit for the S.S. HOPE. Because of unfortunate scheduling of service by HOPE personnel, invitations were issued too late to be effective. However, $500 was presented to HOPE and further activity is planned for next year. The Woman's Auxiliary was also active in holding orientation meetings for foreign physicians and their wives. This activity will be continued.

An AMA Speakers' Training Program was successfully held. While scheduling will not permit this to be an annual event, it is anticipated that another will be held in 1973.

Two seminars for medical assistants were held, each well attended. This is an ongoing project of this committee and will be expanded to cover all parts of the state.

The committee has discussed the possibility of hiring a public relations consultant on a part-time basis. Estimates have been requested of several professional public relations consultants and when final cost estimates can be determined, Council will be requested to allocate sufficient funds.

A local newspaper will be approached in the near future for assistance in issuing a Sunday supplement covering health care in Maryland. This will be patterned after a similar supplement in Massachusetts sponsored by the Massachusetts Medical Society and a local newspaper.

The final project of the year is the planning for a task force to cover the state explaining the various national health insurance programs, the AMA Medicredit bill in particular. AMA has offered assistance to carry out such a program and advantage will be taken of this offer.

Respectfully submitted,

PAUL A. MULLAN, MD, Chairman
ANNIE M. BESTEBREURTJE, MD
LIONEL A. DESBORDES, MD
RAYMOND J. DONOVAN, JR., MD
WILLIAM DUNSEATH, MD
GUNTHER D. HIRSCH, MD
LEEDS E. KATZEN, MD
SOL B. LOVE, DDS
JOHN O. SHARRETT, MD
ROBERT J. THOMAS, MD
MRS. H. LEONARD WARRES
RICHARD A. YOUNG, MD

## TREASURER

*Mr. President and Members of the House of Delegates:*

The annual audit of the Treasurer of the Medical and Chirurgical Faculty has been completed. The financial reports for the year ended Dec 31, 1971 will be published, as usual, in the *Maryland State Medical Journal* prior to the Semiannual Meeting.

The 1972 Budget, which you have before you, was approved by the Council at its January 1972 meeting. It was very carefully drafted and amended to its final form. The Executive Committee and representatives from component medical societies reviewed each item in detail prior to Council approval. The Budget will also be published in the *Maryland State Medical Journal.*

Respectfully submitted,

KARL F. MECH, MD, Treasurer

## 1972 ESTIMATED INCOME

| | 1971 THROUGH NOVEMBER | | 1972 BUDGET | |
|---|---|---|---|---|
| **DUES** | | | | |
| Component Society Members | $252,669.00 | | $330,000.00 | |
| Baltimore City Dental Society | 1,820.00 | | 1,820.00 | |
| | | $254,489.00 | | $331,820.00 |
| **RENTS & SERVICES** | | | | |
| Baltimore City Medical Society | 26,000.00 | | 24,000.00 | |
| Board of Medical Examiners | 6,200.00 | | 7,900.00 | |
| Maryland League for Nursing | 385.00 | | 420.00 | |
| Med-Chi Insurance Trust | 12,750.00 | | 13,451.00 | |
| | | 45,335.00 | | 45,771.00 |
| **INVESTMENT INCOME** | | | | |
| Restricted Fund Earnings | 4,638.92 | | 4,600.00 | |
| Short Term Interest | 6,434.96 | | 7,000.00 | |
| | | 11,073,88 | | 11,600.00 |
| **MEDICAL JOURNAL** | | 55,562.34 | | 60,000.00 |
| **ANNUAL & SEMIANNUAL MEETINGS** | | 15,861.00 | | 16,000.00 |
| **OTHER** | | 4,073.18 | | 2,000.00 |
| **TOTAL** | | **$386,394.40** | | **$467,191.00** |

## 1972 ESTIMATED EXPENDITURES

| | Budget 1971 | Actual through November | Budget 1972 | |
|---|---|---|---|---|
| Auditing | $ 2,600.00 | $ 2,762.75 | $ 3,000.00 | |
| Legal | 10,000.00 | 6,365.00 | 10,000.00 | |
| Contributions | 1,000.00 | 550.00 | 1,000.00 | A* |
| Fuel | 2,000.00 | 1,709.40 | 2,500.00 | |
| Gas, Electricity, Water | 5,500.00 | 6,042.82 | 6,500.00 | B* |
| Telephone & Telegraph | 6,000.00 | 6,150.99 | 6,500.00 | C* |
| Postage | 7,500.00 | 6,979.45 | 7,500.00 | |
| Household & Janitorial | 2,000.00 | 2,419.43 | 2,500.00 | |
| Property Maintenance | 3,500.00 | 3,984.74 | 4,000.00 | |
| Insurance | 2,500.00 | 1,522.93 | 2,000.00 | |
| Special Equipment Services | 4,000.00 | 6,253.03 | 5,000.00 | |
| New Equipment | 1,000.00 | 2,662.15 | 2,000.00 | |
| Equipment Maintenance | 1,000.00 | 1,155.39 | 1,500.00 | |
| Stationery & Supplies | 4,000.00 | 2,030.23 | 4,000.00 | |
| Salaries | 212,500.00 | 175,714.09 | 227,658.00 | D* |
| Social Security | 9,300.00 | 8,516.24 | 9,500.00 | |
| Unemployment Compensation | 1,000.00 | 499.43 | 1,500.00 | |
| Employees' Insurance Program | 4,000.00 | 3,232.74 | 4,000.00 | |
| Employees' Pension Program | 10,000.00 | 6,213.28 | 12,000.00 | E* |
| Supplementary Hours Exp. | 2,500.00 | 2,128.29 | 2,500.00 | |
| Travel | 7,500.00 | 5,244.22 | 12,000.00 | F* |
| Printing | 5,000.00 | 4,593.29 | 11,500.00 | G* |
| Data Processing-Membership Records | 3,000.00 | 1,922.81 | 3,000.00 | |
| Legislation | 7,000.00 | 5,610.94 | 7,000.00 | |
| Library | 4,500.00 | 3,362.97 | 5,247.00 | H* |
| Journal Expense | 95,000.00 | 69,229.91 | 80,000.00 | |
| Annual & Seminannual Meetings | 25,000.00 | 27,033.51 | 27,000.00 | |
| Presidential Fund | 1,000.00 | -0- | 1,000.00 | |
| Woman's Auxiliary | 1,000.00 | 1,000.00 | 1,000.00 | |
| Miscellaneous Expenses | 3,000.00 | 3,204.29 | 3,000.00 | |
| **TOTAL** | **$443,900.00** | **$368,094.32** | **$465,905.00** | |

*** See Explanatory Notes**

**A. CONTRIBUTIONS:**

Reflects a reserve for possible requests during the year.

Budgeted items include:

Student American Medical Association:

| | | |
|---|---|---|
| National Chapter | $100.00 | |
| University of Maryland Chapter | 450.00 | |
| Johns Hopkins Chapter | 50.00 | |
| Miscellaneous | 400.00 | |
| | | $1,000.00 |

**B. GAS, ELECTRICITY, AND WATER:**

Reflects an increase in utility rates, as well as projected increase in use of these services.

**C. TELEPHONE AND TELEGRAPH:**

Reflects an increase in charges for these services.

**D. SALARIES:**

Reflects normal salary adjustments that are considered and acted on individually on anniversary dates of employees plus an additional staff employee for the library.

**E. PENSIONS:**

Reflects adjustments made for employer's contribution in accordance with federal requirements, based on salary adjustments made in Item D.

**F. TRAVEL:**

The following is included:

Senior Medical Society Executives Meeting, Chicago, Ill, 2 days, Jan 27-28, one staff member.

Medicolegal Symposium, New York City, March 18-20, one staff member.

Socio-Economics of Health Care, Florida, April 6-7, one staff member.

AMA Annual Convention and Medical Society Executives Association, San Francisco, June 17-22, Three Delegates, Three Alternate Delegates, President, and one staff member.

AMA Clinical Session and Medical Society Executives Association, Cincinnati, Three Delegates, Three Alternate Delegates, President, and one staff member.

Mileage allowance for component society and other travel in state.

Maryland participation in Southeastern States Hospitality room at AMA Annual and Clinical sessions.

Attendance of Committee and Subcommittee chairman; as well as Faculty designees at meetings sponsored by AMA and other associated organizations. These are authorized on an individual basis by the Executive Committee.

**G. PRINTING:**

Reflects the additional cost for the membership directory. This cost was previously included in Journal Expense.

**H. LIBRARY:**

Includes Memberships, Travel, Supplies, Equipment, Copying, Postage, and Miscellaneous Library expenditures. Library salaries are in the Salary account. Journal subscriptions, books, binding, etc are purchased by designated funds and are not included in this item.

# ANNUAL FINANCIAL STATEMENTS
# of the
# Medical and Chirurgical Faculty
# of the State of Maryland

March 22, 1972

## CERTIFICATE

The Medical and Chirurgical Faculty
of The State of Maryland,
1211 Cathedral Street,
Baltimore, Maryland 21201

Gentlemen:

We have made an audit of the records of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1971. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the balance sheet, together with the supporting statements, present fairly the financial position of the Faculty as of December 31, 1971 and the results from operations for the year then ended, in comformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

WOODEN & BENSON

# THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

## Baltimore, Maryland

## BALANCE SHEET—DECEMBER 31, 1971

### GENERAL FUND

| ASSETS | | | | LIABILITIES AND CAPITAL | | | |
|---|---|---|---|---|---|---|---|
| CASH | | | | LIABILITIES | | | |
| Maryland National Bank | | | | Accounts Payable | | | |
| Regular checking | | 405,072.86 | | Trade | | 5,480.07 | |
| Payroll | | 10,580.55 | | American Medical Association—dues collected | | 87,795.00 | |
| Savings Account | | 10,165.50 | | Component Societies—dues collected | | 70,042,00 | |
| Petty cash funds | | 400.00 | 426,218.91 | | | | |
| ACCOUNTS RECEIVABLE | | | | Due to Other Funds | | | |
| Membership dues, journal subscriptions, etc. | | 14,974.96 | | Educational Fund | 13,701.93 | | |
| | | | | Plant Fund | 54,375.39 | 68,077.32 | 231,394.39 |
| Due From Other Funds | | | | Payroll Taxes | | | |
| Consolidated Fund | 12,179.71 | | | Withholdings | | | |
| Harvey G. Beck—Lectureship Fund | 636.25 | | | Federal | | 2,405.44 | |
| George M. Boyer—Lectureship Fund | 393.00 | | | Old age benefits | | 1,031.88 | |
| Jesse C. Coggins—Lectureship Fund | 693.56 | | | Unemployment Insurance | | | |
| J. Mason Hundley—Memorial Fund | 184.05 | | | Federal | | 220.70 | |
| Amos Koontz—Memorial Fund | 433.54 | | | State | | 61.94 | 3,719.96 |
| Steiner Fund | 13,710.91 | | | Accrued Expenses—insurance and pension | | | 3,752.15 |
| Med-Chi Insurance Trust Fund | 2,714.15 | | | Designated Funds | | | |
| Community Health Project Fund | 20.90 | 30,966.07 | 45,941.03 | Library Account—books and journals | | 3,142.01 | |
| LOAN RECEIVABLE | | | | Library Special Project—Regional Medical Program Grant | | 1,420.19 | |
| Plant Fund | | | 30,000.00 | Educational Fund—assessments collected | | 6,825.00 | |
| DEFERRED EXPENSES | | | | Grant E. Ward Lecture Fund | | 3,860.00 | 15,247.20 |
| Air Travel | | 425.00 | | Deferred Income | | | |
| Insurance premiums | | 163.20 | 588.20 | Membership pending election—dues collected | | 3,645.00 | |
| | | | | Dues—1972 | | 138,370.00 | |
| | | | | Baltimore City Medical Society—rents and services | | 975.50 | 142,990.50 |
| | | | | Capital—Exhibit C | | | 105,643.94 |
| | | | 502,748.14 | | | | 502,748.14 |

### ENDOWMENT AND OTHER SPECIAL FUNDS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Consolidated Fund—Exhibit A-1 | | | 355,153.70 | Consolidated Fund—Exhibit A-1 | | | 355,153.70 |
| Funded Reserve—Exhibit A-2 | | | 20,308.97 | Funded Reserve—Exhibit A-2 | | | 20,308.97 |
| Harvey G. Beck—Lectureship Fund—Exhibit A-3 | | | 3,824.42 | Harvey G. Beck—Lectureship Fund—Exhibit A-3 | | | 3,824.42 |
| Jesse C. Coggins | | | | Jesse C. Coggins | | | |
| Lectureship Fund—Cash—Maryland National Bank | | 5,851.37 | | Lectureship Fund—Due General Fund | 693.56 | | |
| New Building Fund—Exhibit A-4 | | 143,349.86 | 149,201.23 | —Capital—Exhibit J | 5,157.81 | 5,851.37 | |
| | | | | New Building Fund—Exhibit A-4 | | 143,349.86 | 149,201.23 |

| | | |
|---|---|---|
| George M. Boyer—Lectureship Fund | | |
| Cash—Loyola Federal Savings and Loan Association | | 5,874.84 |
| Amos Koontz—Memorial Fund—Exhibit A-5 | | 2,840.77 |
| Educational Fund—Exhibit A-6 | | 15,938.67 |
| Medical Annals Fund | | |
| Cash—Suburban Trust Company | | 1,496.55 |
| Henry P. Laughlin—Special Award Fund | | |
| Cash—Loyola Federal Savings and Loan Association | | 3,919.42 |
| J. Mason Hundley Memorial Fund | | |
| Cash—Loyola Federal Savings and Loan Association | | 6,817.11 |
| Lewis H. Steiner Fund—Exhibit A-7 | | 412,730.55 |
| Community Health Project Fund | | |
| Cash—Loyola Federal Savings and Loan Association | | 6,300.46 |
| Total Endowment and Other Special Funds—Assets | | 984,406.69 |

| | | |
|---|---|---|
| George M. Boyer—Lectureship Fund | | |
| Due—General Fund | 393.00 | |
| Capital | 5,481.84 | 5,874.84 |
| Amos Koontz—Memorial Fund—Exhibit A-5 | | 2,840.77 |
| Educational Fund—Exhibit A-6 | | 15,938.67 |
| Medical Annals Fund—Capital—Exhibit M | | 1,496.55 |
| Henry P. Laughlin—Special Award Fund—Capital | | 3,919.42 |
| J. Mason Hundley—Memorial Fund | | |
| Due General Fund | 184.05 | |
| Capital | 6,633.06 | 6,817.11 |
| Lewis H. Steiner Fund—Exhibit A-7 | | 412,730.55 |
| Community Health Project Fund | | |
| Due General Fund | 20.90 | |
| Capital | 6,279.56 | 6,300.46 |
| Total Endowment and other Special Funds—Liabilities and Capital | | 984,406.69 |

## PLANT FUND

| | | | |
|---|---|---|---|
| Cash—Maryland National Bank | | | 144.69 |
| Accounts Receivable—General Fund | | | 54,375.39 |
| Fixed Assets—(No Depreciation Provided) | | | |
| 1215-1217 Cathedral Street—land—cost | | 19,118.95 | |
| 1209-1215 Cathedral Street | | | |
| Land—building—cost | 110,635.76 | | |
| Improvements—cost | 331,525.47 | 442,161.23 | |
| *Personal Property | | | |
| Library books—journals | 231,370.00 | | |
| Office, library, fixtures, antiques and museum pieces | 77,349.48 | | |
| Portraits | 65,000.00 | 373,719.48 | 834,999.66 |
| | | | 889,519.74 |

| | | |
|---|---|---|
| LIABILITIES | | |
| Jesse C. Coggins—New Building Fund | | |
| Principal account | 45,033.02 | |
| Loan Payable—General Fund | 30,000.00 | 75,033.02 |
| Capital—Exhibit O | | 814,486.72 |
| | | 889,519.74 |

## MED-CHI-INSURANCE TRUST FUND

| | | |
|---|---|---|
| Cash—Maryland National Bank—checking account | | 57,901.95 |
| Total Med-Chi Insurance Trust Fund | | 57,901.95 |
| Grand Total—All Funds | | 2,434,576.52 |

| | |
|---|---|
| LIABILITIES | |
| Subscriber overpayments | 21.20 |
| Due General Fund for expenditures | 2,714.15 |
| Edward H. Friend and Company—Consulting Actuaries | 135.00 |
| Premiums collected | 842.78 |
| Others | 100.00 |
| | 3,813.13 |
| Capital—Exhibit P | 54,088.82 |
| Total Med-Chi Insurance Trust Fund | 57,901.95 |
| Grand Total—All Funds | 2,434,576.52 |

* The appraised value of portraits as of December 31, 1963 was $65,000, an increase of $51,000 over prior years.

All other personal property appraised as of December 31, 1949, with subsequent additions at cost.

## STATEMENT OF INCOME, EXPENSES, AND TRANSFERS
## FOR YEAR ENDED DECEMBER 31, 1971

### GENERAL FUND

| | | | |
|---|---|---|---|
| INCOME | | | |
| Dues—Baltimore City Dental Society | 1,820.00 | | |
| —County Medical Societies | 252,781.50 | 254,601.50 | |
| Rents and Services | | | |
| Baltimore City Medical Society | 25,024.50 | | |
| Others | 7,695.00 | 32,719.50 | |
| Meetings—Annual and Semiannual Exhibits | | 15,861.00 | |
| Journal—Advertising | 57,188.83 | | |
| —Subscriptions | 1,884.62 | 59,073.45 | |
| Addressograph services | | 956.36 | |
| Interest on savings accounts | | 7,667.89 | |
| Miscellaneous | | 3,252.00 | |
| | | 374,131.70 | |
| Transfer from Consolidated Fund—Income for General purposes—Exhibit F | | 5,258.49 | |
| Total Income and Transfers—Forwarded | | | 379,390.19 |
| EXPENSES | | | |
| Accounting fees | | 2,762.75 | |
| Communication—postage, telephone, and telegraph | | 14,254.61 | |
| Contributions | | 550.00 | |
| Equipment rental and maintenance | | 8,081.20 | |
| Fuel | | 1,709.40 | |
| Gas, electricity and water | | 6,463.65 | |
| Household and janitorial services | | 2,482.28 | |
| Insurance—general | | 1,845.83 | |
| —hospitalization | | 3,537.18 | |
| Journal expenses—printing and commissions | | 75,017.79 | |
| Legal fees | | 6,365.00 | |
| Legislature | | 5,794.44 | |
| Library | | 4,141.45 | |
| Meetings—annual and semiannual | | 27,587.51 | |
| Data processing—memberships | | 2,788.39 | |
| Office supplies | | 2,096.64 | |
| Pension and major, medical contribution | | 10,000.00 | |
| Printing | | 4,679.29 | |
| Purchase of equipment | | 2,894.45 | |
| Property maintenance | | 4,560.50 | |
| Salaries | | 179,936.92 | |
| Social security | | 9,032.18 | |
| Supplementary hours | | 2,177.08 | |
| Travel | | 7,780.86 | |
| Unemployment insurance—Federal | | 448.79 | |
| —State | | 333.28 | |
| Women's auxiliary | | 1,000.00 | |
| Miscellaneous | | 4,272.42 | |
| Total Expenses | | | 392,593.89 |
| Excess of Expenses over Income and Transfers—To Exhibit C | | | 13,203.70 |

Exhibit C

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## GENERAL FUND

| | |
|---|---|
| January 1, 1971—Balance | 118,847.64 |
| DEDUCTION | |
| Excess of Expenses over Income and Transfers for the year ended December 31, 1971—Exhibit B | 13,203.70 |
| December 31, 1971—Balance—To Exhibit A | 105,643.94 |

Exhibit A-1

## BALANCE SHEET—DECEMBER 31, 1971
## CONSOLIDATED FUND

### ASSETS

| | | | |
|---|---|---|---|
| INCOME ACCOUNT | | | |
| Cash—The Savings Bank of Baltimore—Exhibit F | | | |
| Eugene Cordell Fund | 12,406.98 | | |
| Special Accounts | 33,121.88 | 45,528.86 | |
| Dividends Receivable | | 3,094.86 | |
| Investments | | | |
| Eugene Cordell Fund—Held by Maryland National Bank—Agent—Exhibit F | | | |
| Cash | 645.61 | | |
| Common stocks—Schedule A-4 | 24,813.83 | 25,459.44 | 74,083.16 |
| PRINCIPAL ACCOUNT | | | |
| Held by Maryland National Bank—Agent—Schedule A-1 | | | |
| Cash | | 1,467.55 | |
| Investments—at cost | | | |
| Bonds | | | |
| United States Government and Municipals | 3,578.75 | | |
| Others | 113,471.20 | 117.049.95 | |
| Stocks | | | |
| Preferred | 14,854.15 | | |
| Common | 147,698.89 | 162,553.04 | 281.070.54 |
| Total—Income and Principal Accounts Assets—to Exhibit A | | | 355,153.70 |

### LIABILITIES AND CAPITAL

| | | | |
|---|---|---|---|
| INCOME ACCOUNT | | | |
| Liabilities | | | |
| Due—General Fund—Exhibit F | | 12,179.71 | |
| Capital—Exhibit E | | 61,903.45 | 74,083.16 |
| PRINCIPAL ACCOUNT | | | |
| Capital—Exhibit G | | | 281,070.54 |
| Total—Income and Principal Accounts Liabilities and Capital—To Exhibit A | | | 355,153.70 |

Exhibit A-2

## BALANCE SHEET—DECEMBER 31, 1971

## FUNDED RESERVE

### ASSETS

| | | |
|---|---|---|
| INCOME ACCOUNT—Exhibit H | | |
| Cash—Savings Bank of Baltimore | | 6,139.88 |
| PRINCIPAL ACCOUNT | | |
| Investments—Held by Maryland National Bank—Agent | | |
| Cash | 735.61 | |
| Common Stock—Schedule A-4 | 13,433.48 | 14,169.09 |
| Total—Income and Principal Accounts—Assets—To Exhibit A | | 20,308.97 |

### LIABILITIES AND CAPITAL

| | |
|---|---|
| INCOME ACCOUNT | |
| Capital—Exhibit H | 6,139.88 |
| PRINCIPAL ACCOUNT | |
| Capital—Exhibit H | 14,169.09 |
| Total—Income and Principal Account—Liability and Capital—To Exhibit A | 20,308.97 |

Exhibit A-3

## BALANCE SHEET—DECEMBER 31, 1971

## HARVEY G. BECK—LECTURESHIP FUND

### ASSETS

| | | |
|---|---|---|
| INCOME ACCOUNT | | |
| Cash—Savings Bank of Baltimore | | 1,664.61 |
| PRINCIPAL ACCOUNT | | |
| Investment Held by Maryland National Bank—Agent | | |
| Cash | 190.07 | |
| Common Stock—Schedule A-4 | 1,969.74 | 2,159.81 |
| Total Income and Principal Accounts—Assets—To Exhbit A | | 3,824.42 |

### LIABILITIES AND CAPITAL

| | | |
|---|---|---|
| INCOME ACCOUNTS | | |
| Liabilities | | |
| Due to General Fund | | 636.25 |
| Capital—Exhibit I | | 1,028.36 |
| | | 1,664.61 |
| PRINCIPAL ACCOUNT | | |
| Capital—Exhibit I | | 2,159.81 |
| Total—Income and Principal Accounts—Liabilities and Capital—to Exhibit A | | 3,824.42 |

Exhibit A-4

## BALANCE SHEET—DECEMBER 31, 1971
## JESSE C. COGGINS—NEW BUILDING FUND

### ASSETS

| | | |
|---|---|---|
| PRINCIPAL ACCOUNT | | |
| Cash—Loyola Federal Savings and Loan Association | 34,161.39 | |
| —Maryland National Bank | 935.51 | 35,096.90 |
| Account Receivable—due from plant fund | | 45,033.02 |
| Investments—at cost—Schedule A-4 | | 63,219.94 |
| Total—Principal Account—Assets—To Exhibit A | | 143,349.86 |

### LIABILITIES AND CAPITAL

| | |
|---|---|
| PRINCIPAL ACCOUNT | |
| Liabilities | None |
| Capital—Exhibit Q | 143,349.86 |
| Total—Principal Account—Liabilities and Capital—To Exhibit A | 143,349.86 |

Exhibit A-5

## BALANCE SHEET—DECEMBER 31, 1971
## AMOS KOONTZ—MEMORIAL FUND

### ASSETS

| | |
|---|---|
| PRINCIPAL ACCOUNT | |
| Cash—Loyola Federal Savings and Loan Association | 2,840.77 |
| Total—Principal Account—Assets—To Exhibit A | 2,840.77 |

### LIABILITIES AND CAPITAL

| | |
|---|---|
| PRINCIPAL ACCOUNT | |
| Liabilities | 433.54 |
| Capital—Exhibit K | 2,407.23 |
| Total—Principal Account—Liabilities and Capital—To Exhibit A | 2,840.77 |

Exhibit A-6

## BALANCE SHEET—DECEMBER 31, 1971
## EDUCATIONAL FUND

### ASSETS

| | |
|---|---|
| PRINCIPAL ACCOUNT | |
| Cash—Maryland National Bank—Savings Account | 2,236.74 |
| Due from General Fund | 13,701.93 |
| Total—Principal Account Assets—To Exhibit A | 15,938.67 |

### LIABILITIES AND CAPITAL

| | |
|---|---|
| PRINCIPAL ACCOUNT | |
| Liabilities | None |
| Capital—Exhibit L | 15,938.67 |
| Total—Principal Liabilities and Capital—To Exhibit A | 15,938.67 |

Exhibit A-7

## BALANCE SHEET—DECEMBER 31, 1971

## LEWIS HENRY STEINER FUND

### ASSETS

| | | |
|---|---|---|
| INCOME ACCOUNT | | |
| Cash—Savings Bank of Baltimore | 44,328.23 | |
| Dividend Receivable | 1,103.82 | |
| Total Income Accounts—Assets | | 45,432.05 |
| PRINCIPAL ACCOUNT | | |
| Uninvested Cash—Maryland National Bank | 573.89 | |
| Due from income account—contra | 5,160.41 | |
| Investments—at cost—Schedule A-7 | 361,564.20 | |
| Total Principal Account—Assets | | 367.298.50 |
| Grand Total—Income and Principal Account—Assets—To Exhibit A | | 412,730.55 |

### LIABILITIES AND CAPITAL

| | | |
|---|---|---|
| INCOME ACCOUNT | | |
| Liabilities | | |
| Due to General Fund for Expenditures | 13,710.91 | |
| Due to Principal Account—contra | 5,160.41 | 18,871.32 |
| Capital—Exhibit N | | 26,560.73 |
| Total Income Account—Liabilities and Capital | | 45,432.05 |
| PRINCIPAL ACCOUNT | | |
| Capital—Exhibit N | | 367.298.50 |
| Grand Total—Income and Principal Account—Liabilities and Capital—To Exhibit A | | 412,730.55 |

Exhibit E

## STATEMENT OF CAPITAL

## FOR YEAR ENDED DECEMBER 31, 1971

## CONSOLIDATED FUND—INCOME ACCOUNT

| | |
|---|---|
| December 31, 1970—Balance | 36,643.75 |
| ADDITION | |
| Understatement of investments as of December 31, 1970—Representing profit on stocks sold during year | 987.02 |
| January 1, 1971—Balance—Exhibit F | 37,630.77 |
| ADDITION | |
| Excess of Income over Expenses and Appropriations for year ended December 31, 1971 — Exhibit D | 24,272.68 |
| December 31, 1971—Balance—To Exhibits A-1, and F | 61,903.45 |

## STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS

## FOR YEAR ENDED DECEMBER 31, 1971

## CONSOLIDATED FUND—INCOME ACCOUNT

| | | | |
|---|---|---|---|
| INCOME | | | |
| Distributive Share—Exhibit F | | | |
| Bonds | | | |
| United States Government and Municipal—Schedule A-1 | 122.50 | | |
| Others | 5,782.10 | 5,904.60 | |
| Stocks | | | |
| Preferred—Schedule A-1 | 637.11 | | |
| Common—Schedule A-1 | 13,943.92 | | |
| Less—Direct Share—Charles M. Ellis Fund | 2,287.50 | 11,656.42 | 12,293.53 |
| Interest on special saving account — | | | |
| The Savings Bank of Baltimore—Schedule A-1 | | 1,433.67 | |
| | | 19,631.80 | |
| Less—agency fees—Schedule A-1 | 777.74 | | |
| —brokerage fees—Schedule A-1 | 2,205.21 | 2,982.95 | 16,648.85 |
| DIRECT SHARE—Exhibit F | | | |
| Charles M. Ellis Fund—Common Stock | | 2,287.50 | |
| Investments—Eugene F. Cordell Fund | | | |
| Stocks | | | |
| Common—Schedule A-4 | 543.01 | | |
| Less—agency fees | 33.77 | 509.24 | |
| Gain on sale of securities—Schedule A-4 | 16,505.20 | 17,014.44 | 19,301.94 |
| OTHER INCOME—Exhibit F | | | |
| Sales Ruhrah Fund | | | |
| Library books | | 11,110.85 | |
| Interest on Savings Account | | | |
| Eugene F. Cordell Fund—The Savings Bank of Baltimore | | 583.89 | 11,694.74 |
| | | | 47,645.53 |
| EXPENSES and APPROPRIATIONS—Exhibit F | | | |
| Library—general | | 14,537.16 | |
| Library Payroll, maintenance, etc transferred to general fund | | 5,258.49 | |
| Lectureship | | 1,177.20 | |
| Cordell Fund | | 2,400.00 | 23,372.85 |
| Exess of Income over Expenses and Appropriations—To Exhibit E | | | 24,272.68 |

Exhibit F

# STATEMENT OF RECEIPTS, EXPENSES AND BALANCES
## FOR YEAR ENDED DECEMBER 31, 1971
## CONSOLIDATED FUND—INCOME ACCOUNT

| Fund | Distributive Share (Percent) | Balance January 1, 1971 (as revised) | Income Received During Year | | | Balance January 1, 1971 Plus Receipts | Library | Expenses Transferred to General Fund (Exhibit B) | Lectureship | Other | Balance December 31, 1971 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Investment Income | | | | | | | | Cash Investments and Dividends Receivable | Cash on Deposit |
| | | | Distributive Share | Direct Share | Other Income | | | | | | | |
| Baker | .65 | 229.74 | 108.22 | | | 337.96 | 57.03 | | | | 280.93 | |
| Barker, Lewellyn F. | .39 | 154.68 | 64.93 | | | 219.61 | | | | | 219.61 | |
| Bowen, Josiah, S. | 9.17 | — | 1,526.70 | | | 1,526.70 | | 1,526.70 | | | — | |
| Bressler, Frank C. | 1.80 | — | 299.68 | | | 299.68 | | 299.68 | | | — | |
| Cordell, Eugene Fauntleroy | 3.64 | 20,268.09 | 606.02 | 17,014.44 | 583.89 | 38,472.44 | | | | 2,400.00 | 36,072.44 | 12,406.98 |
| Cowles, Nellie N. | .75 | 1,143.21 | 124.87 | | | 1,268.08 | 7.87 | | | | 1,260.21 | |
| Ellis, Charles M. | — | — | — | * 2,287.50 | | 2,287.50 | | 2,287.50 | | | — | |
| Finney, John M. T. | 8.40 | 6,078.32 | 1,398.50 | | | 7,476.82 | 3,059.12 | | 372.00 | | 4,045.70 | |
| Frick, William F. | 15.02 | ( 299.33) | 2,500.66 | | | 2,201.33 | 2,201.33 | | | | | |
| Friedenwald, Julius F. | .75 | — | 124.87 | | | 124.87 | | 124.87 | | | | |
| Harlan, Herbert | .76 | 230.95 | 126.53 | | | 357.48 | 140.75 | | | | 216.73 | |
| McCleary, Standish | .75 | 180.75 | 124.87 | | | 305.62 | 43.24 | | 150.00 | | 112.38 | |
| Osler Endowment | 1.40 | 822.97 | 233.08 | | | 1,056.05 | 1,682.77 | | | | (626.72) | |
| Osler Testimonial | 7.75 | 4,624.76 | 1,290.28 | | | 5,915.04 | | 645.14 | | | 5,269.90 | |
| Ruhrah, John | 40.79 | (1,393.64) | 6,791.06 | | 11,110.85 | 16,508.27 | 7,134.23 | | | | 9,374.04 | |
| Stokes, William Royal | 3.09 | 1,111.17 | 514.45 | | | 1,625.62 | 210.82 | | 300.00 | | 1,114.80 | |
| Trimble, Isaac Ridgeway | 2.64 | 4,479.10 | 439.53 | | | 4,918.63 | | | 355.20 | | 4,563.43 | |
| Woods, Hiram | 2.25 | — | 374.60 | | | 374.60 | | 374.60 | | | — | |
| | 100.00 | *37,630.77 | *16,648.85 | 19,301.94 | 11,694.74 | 85,276.30 | 14,537.16 | 5,258.49 | 1,177.20 | 2,400.00 | *61,903.45 | 12,406.98 |
| | | *To Exhibit E | *Total to Exhibit D *To Schedule A-1 | | | | Total to Exhibit D | | | | *To Exhibit E | To Summary |

**SUMMARY**—To Exhibit A-1

| | | |
|---|---|---|
| CASH | | |
| Individual Accounts—above | 12,406.98 | |
| Special Accounts | 33,121.88 | |
| Dividends Receivable | 3.094.86 | 48,623.72 |
| CORDELL FUND | | |
| Cash | 645.61 | |
| Investments | 24,813.83 | 25,459.44 |
| | | 74,083.16 |
| Less—Accounts payable to Other Funds | | 12,179.71 |
| | | 61,903.45 |

# STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## CONSOLIDATED FUND—PRINCIPAL ACCOUNT

| Fund | Purpose | Balance December 31, 1970 | **Understatement of Investments as of December 31, 1970 | Balance January 1, 1971 | Net Profit on Security Sales | Balance December 31, 1971 |
|---|---|---|---|---|---|---|
| Baker | Book of Materia Medicine | 1,535.28 | 80.85 | 1,616.13 | 160.28 | 1,776.41 |
| Barker, Lewellyn F. | Library | 921.18 | 48.53 | 969.71 | 96.17 | 1,065.88 |
| Bowen, Joseph S. | General | 21,617.77 | 1,140.27 | 22,758.04 | 2,261.23 | 25,019.27 |
| Bressler, Frank C. | General | 4,242.63 | 223.85 | 4,466.48 | 443.86 | 4,910.34 |
| Cordell, Eugene Fauntleroy | Relief of Widows and Orphans | 8,581.76 | 452.65 | 9,034.41 | 897.59 | 9,932.00 |
| Cowles | Books of Neurology | 1,769.51 | 93.29 | 1,862.80 | 184.94 | 2,047.74 |
| Ellis, Charles M. | General | 8,258.46 | — | 8,258.46 | — | 8,258.46 |
| Finney, John M. T. | Books, Journals and Lectureships on Surgery | 19,792.00 | 1,044.52 | 20,836.52 | 2,071.35 | 22,907.87 |
| Frick, William F. | Maintenance of Frick Library and Purchase of Books and Journals | 35,398.21 | 1,867.68 | 37,265.89 | 3,703.77 | 40,969.66 |
| Friedenwald, Dr. Julius | Maintenance of Friedenwald Room | 1,769.52 | 93.29 | 1,862.81 | 184.94 | 2,047.75 |
| Harlan, Herbert | Books on Ophthalmology | 1,794.98 | 94.54 | 1,889.52 | 187.41 | 2,076.93 |
| McCleary, Standish | Lectureships and Books on Pathology | 1,769.52 | 93.29 | 1,862.81 | 184.94 | 2,047.75 |
| Osler Endowment | Permanent Endowment for Library by Request of Dr. Osler | 3,295.27 | 174.12 | 3,469.39 | 345.23 | 3,814.62 |
| Osler Testimonial | Medical Books and Maintenance of Osler Hall | 18,262.84 | 963.70 | 19,226.54 | 1,911.07 | 21,137.61 |
| Ruhrah, John | Library, Books, Journals, etc. | 96,140.29 | 5,072.03 | 101,212.32 | 10,058.39 | 111,270.71 |
| Stokes, William Royal | Lectureship and Books on Bacteriology or Pathology | 7,289.95 | 384.26 | 7,674.21 | 761.96 | 8,436.17 |
| Trimble, John Ridgeway | Lectureship only | 6,225.59 | 328.30 | 6,553.89 | 650.99 | 7,204.88 |
| Woods, Hiram | General | 5,311.85 | 279.81 | 5,591.66 | 554.83 | 6,146.49 |
| | | 243,976.61 | 12,434.98 | 256,411.59 | *24,658.95 | 281,070.54 |
| | | | | | Schedule A-1 | To Exhibit A-1 |

**Unrecorded profit on stocks sold during year neded December 31, 1970.

Exhibit H

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971

## FUNDED RESERVE

### INCOME ACCOUNT

| | | |
|---|---|---|
| December 31, 1970—Balance | | 5,506.24 |
| DEDUCTION | | |
| Due to Funded Reserve Principal | | 480.34 |
| January 1, 1971—Balance | | 5,025.90 |
| ADDITIONS | | |
| Dividends—Schedule A-4 | 902.60 | |
| Interest—Savings Account | 265.54 | 1,168.14 |
| | | 6,194.04 |
| DEDUCTION | | |
| Agency fees | | 54.16 |
| December 31, 1971—Balance—To Exhibit A-2 | | 6,139.88 |

### PRINCIPAL ACCOUNT

| | |
|---|---|
| December 31, 1970—Balance | 13,688.75 |
| ADDITIONS | |
| Due from Funded Reserve Income | 480.34 |
| January 1, 1971—Balance | 14,169.09 |
| Transactions | None |
| December 31, 1971—Balance—To Exhibit A-2 | 14,169.09 |

Exhibit J

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971

## JESSE C. COGGINS—LECTURESHIP FUND

| | |
|---|---|
| January 1, 1971—Balance | 5,358.58 |
| ADDITION | |
| Interest—Savings Account | 245.29 |
| | 5,603.87 |
| DEDUCTION | |
| Reimbursement to General Fund for expenditures | 446.06 |
| December 31, 1971—Balance—To Exhibit A | 5,157.81 |

Exhibit I

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## HARVEY G. BECK—LECTURESHIP FUND

### INCOME ACCOUNT

| | | |
|---|---|---|
| January 1, 1971—Balance | | 1,231.80 |
| ADDITIONS | | |
| Dividends—Schedule A-4 | 213.20 | |
| Interest—Savings Account | 72.41 | 285.61 |
| | | 1,517.41 |
| DEDUCTIONS | | |
| Agency fees | 12.80 | |
| Reimbursement to General Fund for expenditures | 476.25 | 489.05 |
| December 31, 1971—Balance—To Exhibit A-3 | | 1,028.36 |

### PRINCIPAL ACCOUNT

| | |
|---|---|
| January 1, 1971—Balance | 2,132.91 |
| ADDITION | |
| Gain on sale of 82 American Telephone and Telegraph stock rights—Schedule A-4 | 26.90 |
| December 31, 1971—Balance—To Exhibit A-3 | 2,159.81 |

Exhibit K

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## AMOS KOONTZ—MEMORIAL FUND

### PRINCIPAL ACCOUNT

| | |
|---|---|
| January 1, 1971—Balance | 2,703.07 |
| ADDITION | |
| Interest—Savings Account | 137.70 |
| | 2,840.77 |
| DEDUCTION | |
| Reimbursement to General Fund for expenditures | 433.54 |
| December 31, 1971—Balance—To Exhibit A-5 | 2,407.23 |

Exhibit L

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## EDUCATIONAL FUND

### PRINCIPAL ACCOUNT

| | | |
|---|---|---|
| January 1, 1971—Balance | | 33,109.21 |
| ADDITION | | |
| Investment income | | 1,694.53 |
| | | 34,803.74 |
| DEDUCTIONS | | |
| Medic network | 2,988.95 | |
| Educational expense | 15,876.12 | 18,865.07 |
| December 31, 1971—Balance—To Exhibit A-6 | | 15,938.67 |

Exhibit M

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## MEDICAL ANNALS FUND

| | | |
|---|---|---|
| January 1, 1971—Balance | | 1,431.53 |
| ADDITION | | |
| Interest on Savings Account | | 65.02 |
| December 31, 1971—Balance—To Exhibit A | | 1,496.55 |

Exhibit N

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## LEWIS H. STEINER FUND

### INCOME ACCOUNT

| | | |
|---|---|---|
| January 1, 1971—Balance | | 25,946.81 |
| ADDITIONS | | |
| Investment income—Schedule A-7 | 13,004.35 | |
| Interest—Savings Account | 1,898.91 | 14,903.26 |
| | | 40,850.07 |
| DEDUCTIONS | | |
| Agency fee | 578.43 | |
| Reimbursement to General Fund for purchase of library books | 13,710.91 | 14,289.34 |
| December 31, 1971—Balance—To Exhibit A-7 | | 26,560.73 |

### PRINCIPAL ACCOUNT

| | |
|---|---|
| January 1, 1971—Balance | 375,248.59 |
| DEDUCTION | |
| Loss on sale of securities—Schedule A-7 | 7,950.09 |
| December 31, 1971—Balance—To Exhibit A-7 | 367.298.50 |

Exhibit O

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## PLANT FUND

| | | |
|---|---|---|
| January 1, 1971—Balance | | 801,196.33 |
| ADDITIONS | | |
| Assessments | 20,495.00 | |
| Interest income | 1,498.39 | 21,993.39 |
| | | 823,189.72 |
| DEDUCTION | | |
| Building repairs | | 8,703.00 |
| December 31, 1971—Balance—To Exhibit A | | 814,486.72 |

Exhibit P

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## MED-CHI INSURANCE TRUST FUND

| | | | |
|---|---|---|---|
| January 1, 1971—Balance | | | 35,458,82 |
| ADDITION—NET | | | |
| Income | | | |
| Administrative fees | 24,368.14 | | |
| Interest on securities | 8,036.31 | | |
| Retirement program | 4,737.00 | 37,141.45 | |
| Expenses | | | |
| Equipment | 130.00 | | |
| Insurance | 575.00 | | |
| Fees—auditing | 300.00 | | |
| —consulting | 2,812.76 | | |
| Postage, stationery and supplies, etc. | 1,943.69 | | |
| Administrative | 12,750.00 | 18,511.45 | |
| | | | 18,630.00 |
| December 31, 1971—Balance—To Exhibit A | | | 54,088.82 |

Exhibit Q

## STATEMENT OF CAPITAL
## FOR YEAR ENDED DECEMBER 31, 1971
## JESSE C. COGGINS—NEW BUILDING FUND

| | | |
|---|---|---|
| January 1, 1971—Balance | | 140,443.45 |
| ADDITIONS | | |
| Gain on sale of securities—Schedule A-4 | 20.49 | |
| Interest on Savings Account | 1,635.38 | |
| Investment income—Schedule A-4 | 1,330.37 | 2,986.24 |
| | | 143,429.69 |
| DEDUCTION | | |
| Agency fees | | 79.83 |
| December 31, 1971—Balance—To Exhibit A-4 | | 143,349.86 |

## WOMAN'S AUXILIARY

*Mr. President and Members of the House of Delegates:*

A milestone in our progress was the organizing of a twelfth county auxiliary, that of Anne Arundel. A nucleus of Members-at-Large from the county discussed forming their own auxiliary early in the winter, and by spring the deed was done. The group was officially installed on April 11, 1972, with Mrs. Sergio Alvarez as president.

The exotic setting for our semiannual meeting, held at El Conquistador outside of San Juan, Puerto Rico, lent a bit of glamour to the proceedings. The Auxiliary sponsored a luncheon at which Governor Evans of the Virgin Islands, himself a physician, was the guest of honor. Also present were notables from the Department of Health of Puerto Rico and from the University.

The highly successful two-day Workshop and Board Meeting, held in November at the Friendship International Hotel, was very well attended. AMAERF Chairman Mrs. Elmer G. Linhardt had a large display of sale objects and a well-worked-out program for her group. Her guest, National AMAERF Chairman Mrs. Ben Johnson, conducted the ERF meeting. On the following morning she addressed the entire group at the Board Meeting. Mrs. Linhardt will have an exhibit at the State Convention with auxiliarians to help staff it. Also, she will award certificates to the counties raising the most ERF funds according to their size. Following the first evening's dinner, the legislative chairman, Mrs. Pedro DeBorja, invited all those attending to a unique "pajama caucus" in her room. She showed a film and told about PAC aims and the proposed Medicredit legislation. Her well-chosen refreshments added to the success of the caucus.

International Health Chairman Mrs. Leopoldo Gruss raised $500 for the Ship Hope through a theatre benefit. She also held an afternoon reception for the wives of foreign doctors. Mrs. Charles H. Williams collected an enormous amount of much-needed material for a hospital in Honduras. She, too, will have an exhibit of her work at the state convention.

Reading the county reports gives one pride in the Auxiliary. These dedicated women have raised great sums of money for needed projects. Mrs. Linhardt reports receiving $14,000 to date for ERF from the counties. Besides contributing to ERF, their money has gone for scholarships and noninterest bearing loans to students in health careers, to Mental Health Day Care Centers, to the High School Career Clubs, to the Wasama group, for furniture for waiting areas in county health clinics, and many other projects. Besides this, the counties provided volunteers for health clinics and arranged programs for nursing homes. They each honored Doctors' Day with their own program and their displays will be used by the Councilor to Southern Medical Auxiliary for showing at the Southern Medical Convention.

We are deeply grateful to our state medical society for its cooperation and encouragement, as well as being deeply appreciative for the $1,000 check contributed to our treasury. We all say "Thank you."

MRS. ROBERT A. REITER, President

## SPECIAL COMMITTEES

### AD HOC COMMITTEE ON NEW FACULTY BUILDING

*Mr. President and Members of the House of Delegates*:

Your Building Committee has held several meetings during the past year and has examined and discussed many locations throughout the Greater Baltimore Area. Some of these locations cannot be mentioned because of the confidential nature of the discussions that have been held with the principals.

However, the Ad Hoc Committee on a New Faculty Building has a recommendation to make with respect to the purchase of land on which a new Faculty building could be built. Please bear in mind that you are not acting on the necessity of a new building or the erection of such a new building, but only on the purchase of land. Any further action in this regard would also have to be approved by this House of Delegates.

The location of this land can be seen on the slide which will be flashed on the screen. It is at a conflux of Routes 29, 70N, and 40 and has sewer and water available. It is available at a price of $10,000 per acre from a hospital (which must remain anonymous at this time) which owns approximately 150 acres at this location.

The land portion which the Faculty can purchase would consist of at least ten and not more than 20 acres and is located at the opposite end of the tract from which it is anticipated a hospital complex will be located.

It is zoned for the type of building in which the Faculty is interested. It is also pointed out that land in this area commands a considerably higher price than what is currently being asked of the Faculty. Should it be the decision of the House of Delegates not to build then the property could, the Building Committee is sure, be sold at a profit, but certainly not for less than what was paid for it.

Your Building Committee, therefore, recommends adoption of the following motion:

> That the Ad Hoc Committee on a New Faculty Building is hereby authorized to purchase at least ten but not more than 20 acres of land at the conflux of Routes 29, 40, and 70N located in Howard County, with the exact location of the land to be determined in negotiation with the principals at a price of $10,000 per acre.

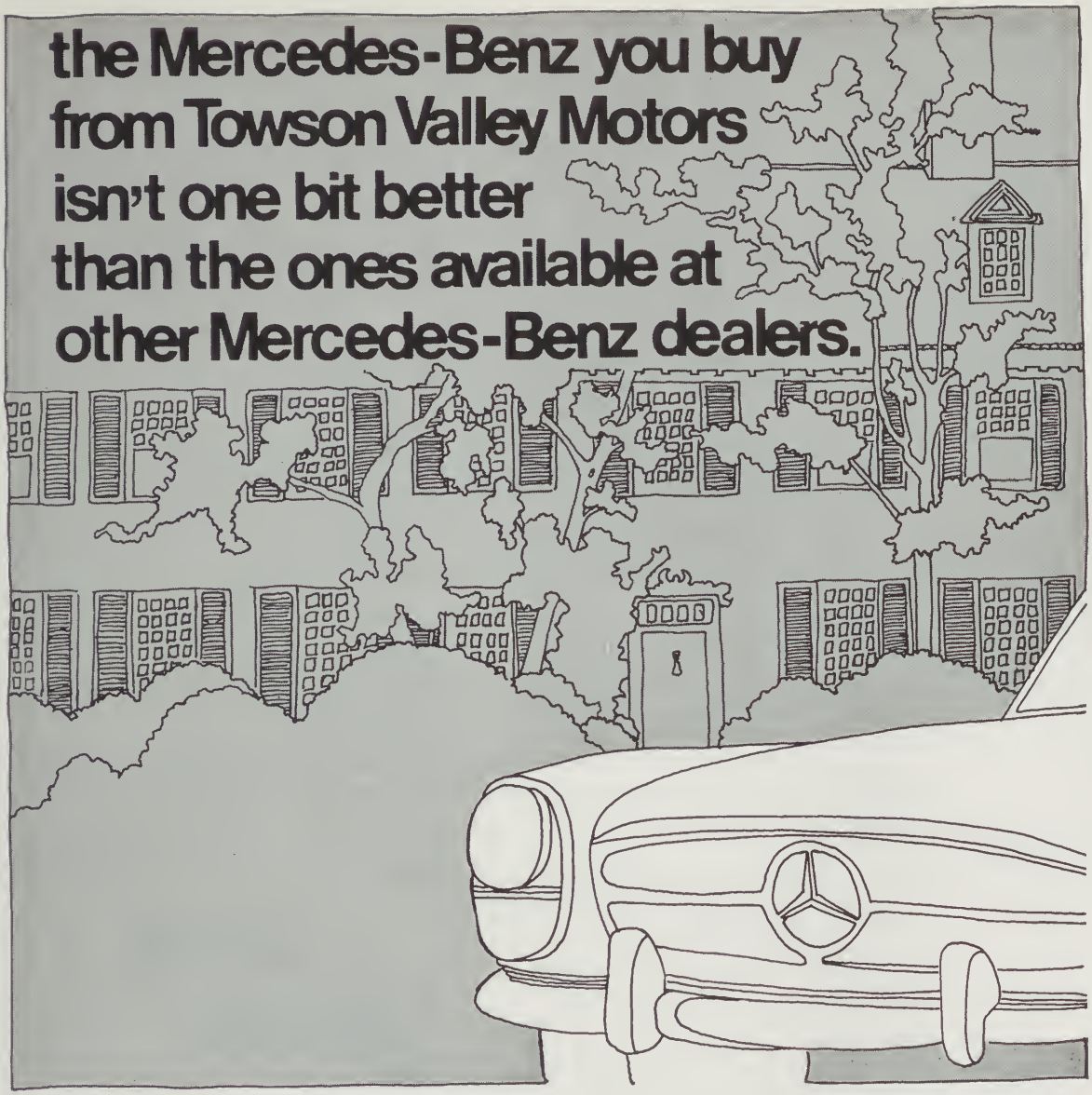
Respectfully submitted,

RUSSELL S. FISHER, MD, Baltimore, Chairman
M. McKENDREE BOYER, MD, Damascus
A. C. DICK, MD, Chestertown
E. W. Ditto, Jr., MD, Hagerstown
PAUL F. GUERIN, MD, Baltimore
JAMES R. KARNS, MD, Baltimore
HENRY A. BRIELE, MD, Salisbury
WILLIAM J. McCLAFFERTY, MD, Baltimore

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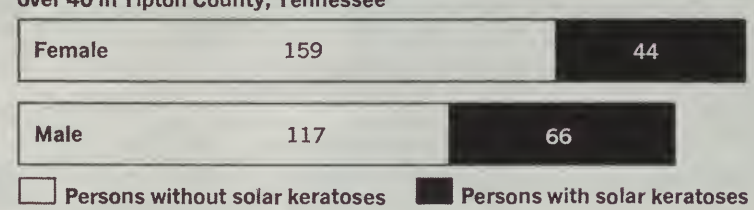
# What it means to live and work in Tipton County, Tennessee

## Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee**




*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



## Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

## Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

## Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

## 5% cream–a Roche exclusive

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

**Before prescribing, please consult complete product information, a summary of which follows:**
**Indications:** Multiple actinic or solar keratoses.
**Contraindications:** Patients with known hypersensitivity to any of its components.
**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.
**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.
**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.
**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.
**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.
Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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# BALTIMORE COUNTY MEDICAL ASSOCIATION



SCHOLARSHIPS—Winners of the recent scholarships for nurses' training, sponsored by the Baltimore County Medical Association, were Robyn Martin (left), graduate of Dundalk Senior High, who will go into nurses' training at Maryland General Hospital; and Nora Carmichael (right), Catonsville Senior High graduate, who will enter training at Sinai Hospital of Baltimore. These scholarships are presented by the Baltimore County Medical Association and monitored by their Women's Auxiliary. Mrs. Elizabeth Fesus (center), is chairman of the Scholarship Committee.

The Baltimore County Medical Association met at the Flaming Pit Restaurant in Timonium on Wednesday, May 17, 1972. The meeting was called to order by the president, Herbert Levickas, MD, after which he welcomed the Woman's Auxiliary. The minutes of the previous meeting were approved.

The report of the Board of Governors was given by John Krager, MD, chairman. The Association has been taxed for the first time by the state and local governments for office equipment. The treasurer, Eugene Riley, MD, has consulted our attorney and he will have a report for the next meeting.

The Association will celebrate its 75th anniversary this year and suggestions from the members as to how to celebrate this occasion will be appreciated. The Peer Review Committee is spending a great deal of time in evaluating Emergency Room procedures in the emergency rooms of the hospitals in Baltimore County. The Hospital Committee approved the request of the Pickersgill Nursing Home to add more rooms in their facility. The approval was requested by the Regional Planning Council.

The Board of Education, in response to our request, will develop a pilot program in six of the secondary school in Baltimore County on venereal disease. This will be extended to all the secondary schools in Baltimore County if successful. In addition to this, the Board of Education has a program for senior high schools on breast and uterine cancer. This program involves the girls, mothers, and female faculty members.

There apparently has been some misunderstanding concerning the directive which came from the office of Neil Solomon, MD, relative to transportation of accident victims. The emergency medical technicians would decide if the patient should go to the Shock and Trauma Unit at the University. The Board of Governors considered this matter and after discussion referred the matter to Eugene Riley, MD, who is a member of the Ad Hoc Committee of the Medical and Chirurgical Faculty on Emergency Medical Care. He will bring a report to the next meeting.

The Greater Towson Chamber of Commerce has prepared a book on Baltimore County and has offered enough copies for our active members if the association will pay for mailing the books. These books are to be placed in physicians' waiting rooms. Additional books can be purchased at $1.50 per copy. An appropriate note will be placed on each book notifying the reader that this book has been provided through the courtesy of the Chamber of Commerce and Baltimore County Medical Association.

The Board of Governors Report was accepted.

**Program Committee**—B. B. Velez, MD, announced the June meeting would be held at St. Agnes Hospital. There will be no July meeting.

**Nursing Scholarships**—Dr. Levickas introduced Mrs. Andre Fesus, chairman of the Nursing Scholarship Committee, who then introduced Miss Robyn Martin, a graduate from the Dundalk Senior High School, who will enter Maryland General Hospital Nursing Program; and Miss Nora Carmichael, a graduate from the Catonsville Senior High School, who will enter the Sinai Hospital Nursing Program. The young ladies responded with thanks. Dr. Levickas wished them much success.

**Program**—Dr. Velez introduced Richard Heller, MD, a member of the Baltimore County Medical Association, who acquainted the members with the program at Johns Hopkins on "Prenatal Diagnosis." Dr. Levickas and Lester N. Kolman, MD, public relations chairman, have had several radio programs on WCAO on Sundays at 10:30 AM. From reports received from WCAO, these programs have been very well accepted. Inasmuch as there was no further business, the meeting was adjourned.

LESTER N. KOLMAN, MD
Public Relations Chairman



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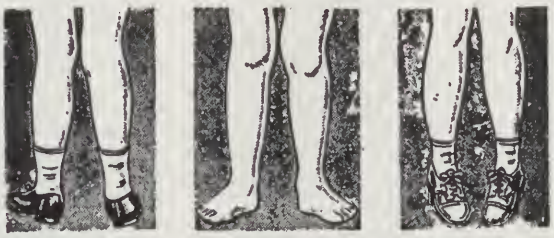
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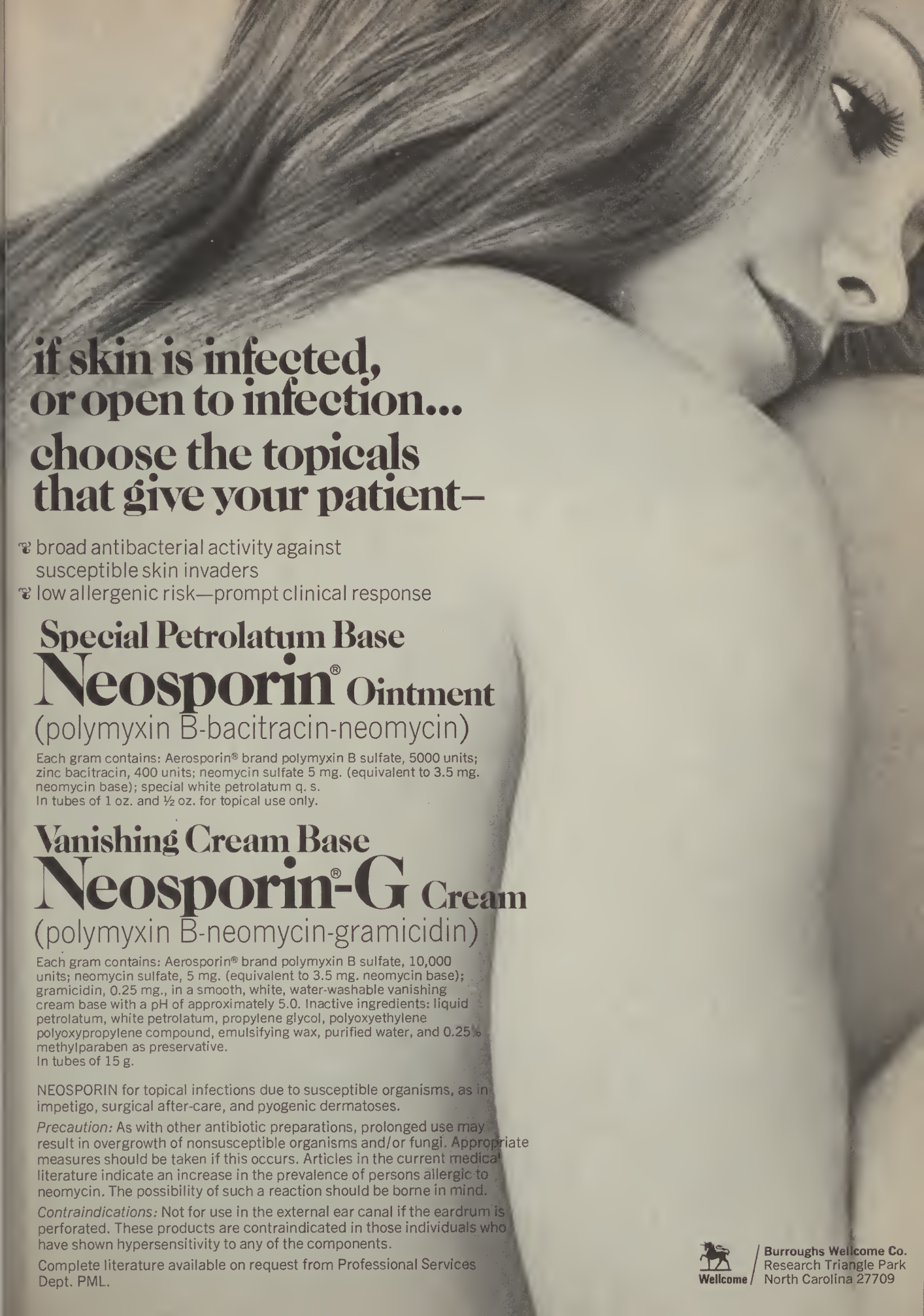
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NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

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# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

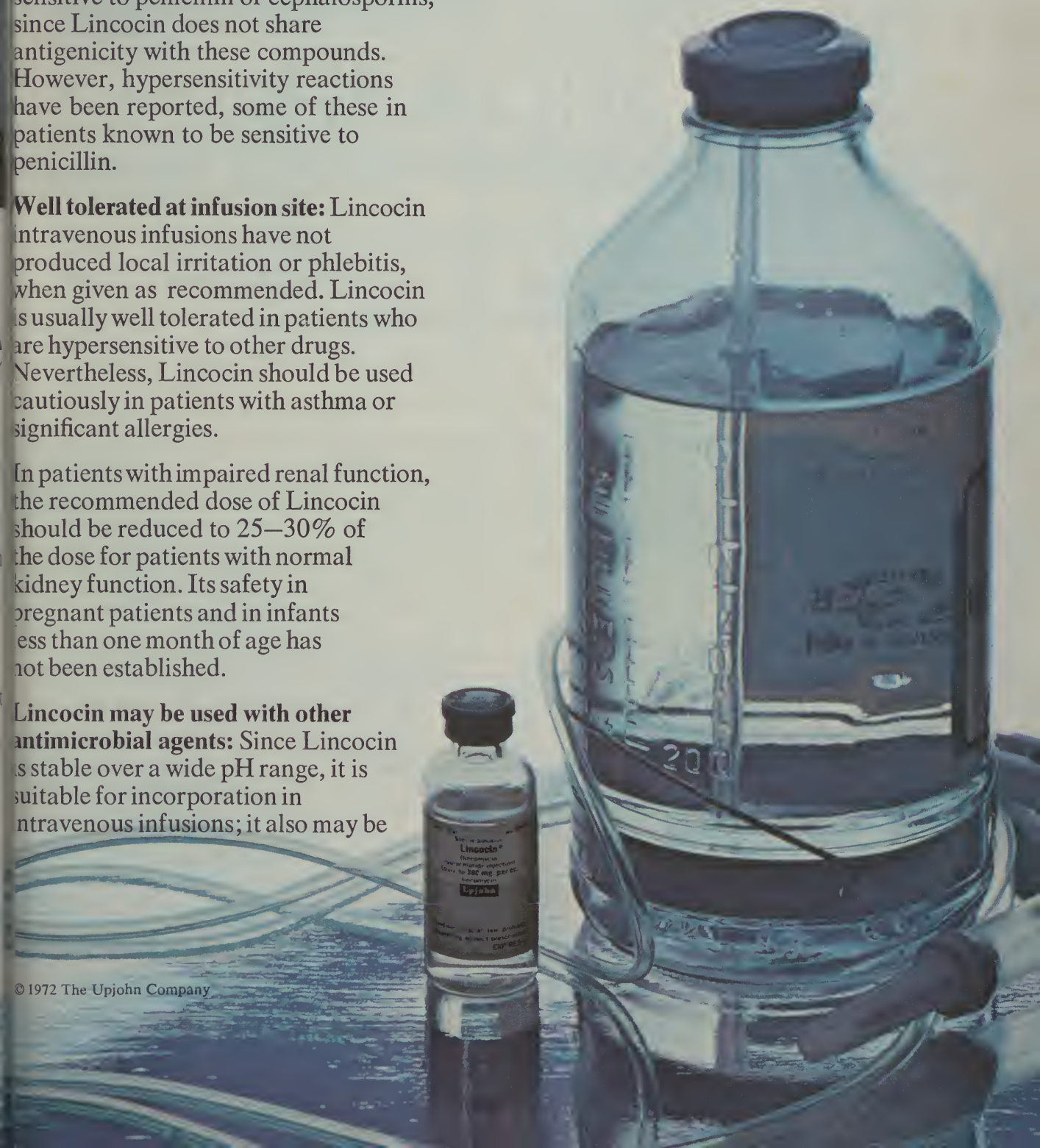
**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.




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Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

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| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct re lationship to liver dysfunction is established jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular* —Instances of hypotension following parenteral administration have been reported particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reaction* —Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 mg* Capsules—bottles of 24 and 100. *Sterile Solution, 300 mg per ml*—2 and 10 ml vials and 2 ml syringe. *Syrup, 250 mg per 5 ml* —60 ml and pint bottles.

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# SLA BOSTON 1972

The 63rd Special Libraries Association Conference in Boston, June 4-8, was attended by over 2,300 librarians. "People-centered services" was the theme of the conference. The lecture topics, and the scheduling of seminars and informal discussion circles provided a welcome opportunity to compare Med-Chi's library with other similar institutions, to learn how other libraries are handling problems, and to study new technological developments and applications that may help libraries of the future provide better services.

One of the general sessions was devoted to an idea exchange. About 150 discussion circles were set up, each with a specific subject. Participants were provided with a list of the subjects, and were free to go from one circle to another as they chose. I sat in on circles dealing with rare books, binding, periodicals, reference services in a small library, copy machines and the copyright law, and book selection.

Compared with a good number of similar libraries, Med-Chi can be justly proud of its actions through the Ash Project to establish and maintain the library's rare book and history of medicine section. Also, in terms of reference services, Med-Chi's library looked good. There were libraries with larger staffs than ours, who didn't feel that they could afford the time to do literature searches.

I had hoped to get some ideas on how other libraries managed their periodical collections. But no one seemed satisfied with their operations. One librarian said, "We are all doing everything wrong, and we come here to find out if we are doing the wrong things for the right reasons." This circle did give me a chance to talk with some publishers and subscription agencies.

Another general session was devoted to "Electronics in Libraries." A variety of computer-based, information-handling systems were exhibited and demonstrated in one room. At the same time a number of papers were offered on the use of "automation" in libraries. Emphasis was on the small library and on what aspects of automation a small library with a small budget could take advantage of. Still, as one of the talks pointed out, in small, special libraries, there is a threshold below which automation should not be attempted.

I was especially impressed with the American Institute of Physics' exhibit on **Current Physics Microform.** Each monthly edition of CPM carries the full text of all articles that appeared the preceding month in 34 American Institute of Physics primary journals. This amounts to about 8,500 pages a month. Retrieval of an article is achieved either automatically or manually. This system should make it easier for libraries to provide photo-duplicated copies of articles easily, quickly, and economically. Someday, perhaps such a system can be developed for the primary medical journals.

The Biological Sciences Division and the Pharmaceutical Division held a joint session on the concept of multiphasic health screening. The papers presented included one on experiences with an operational system, and one reporting the results of a survey of patient and physician opinions about multiphasic health testing.

A talk entitled "Are Hospital Libraries Meeting Physicians' Information Needs?" discussed the results of a 1970 Connecticut study. The paper and its statistics merit study by all medical librarians. Among the conclusions: Physicians tend to rely more upon communication with colleagues than upon reading as a means of keeping informed and up to date; also, three times as many physicians rely on their own personal subscriptions as on library holdings.

The conference lasted six days. Much more was

covered than the few highlights I have mentioned. I concluded my stay in Boston by taking Friday morning to visit and tour the Francis A. Countway Library of Medicine of the Harvard Medical School, again trying to study the methods employed by other libraries to handle problems and to better serve the needs of their clientele.

JOSEPH JENSEN
Assistant Librarian

## NEW ACCESSIONS – BOOKS
## (Arranged by Subjects)

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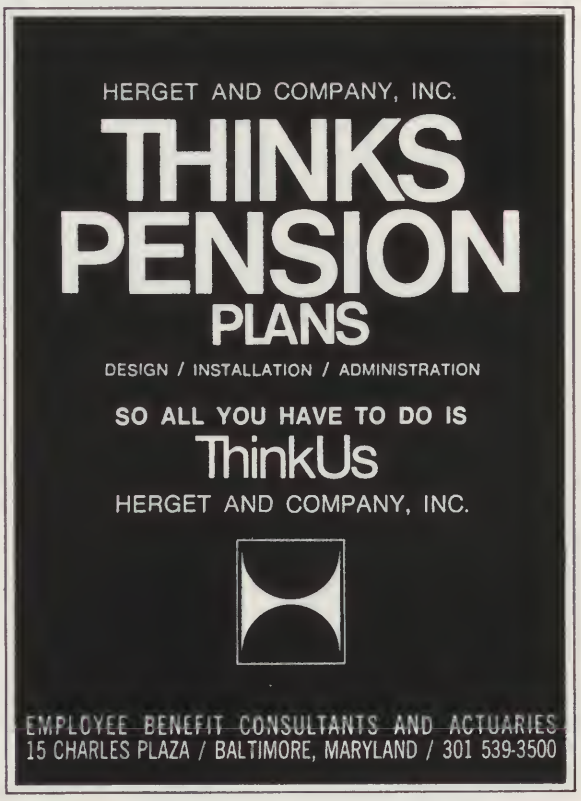
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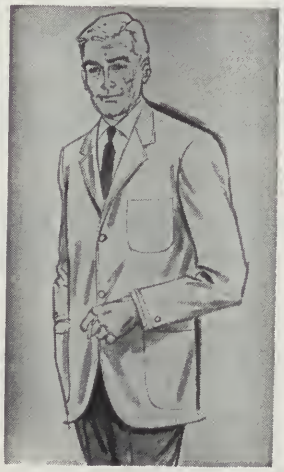
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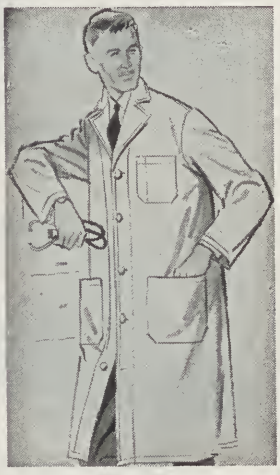
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A & F Nurses Registry ..... 104

Aloha Carnival ..... 13

AMA Medicredit ..... 96

Arundel Fed. Savings & Loan Assoc. ..... 29

Baltimore Nurses Exchange ..... 30

Beecham-Massengill Pharm. ..... 33, 35, 37

Burroughs Welcome Co. ..... 97

Capital Savings & Loan Association ..... 90

Oscar Caplan & Sons ..... 10

Dow Pharmaceuticals ..... 2

Dulaney Towson Nursing and Convalescent Home ..... 13

Fairfield Medical ..... 105

Franklin Uniform Co. ..... 105

Geigy Pharmaceuticals ..... 1, 20-21

James A. Griffin ..... Cover 3

Herget & Co. ..... 103

Hospital Affiliates ..... 106

Eli Lilly & Co., Inc. ..... 48

Manekin Management Inc. ..... 95

Pharmaceutical Mfrs. Assoc. ..... 45-47

Wm. P. Poythress Co., Inc. ..... 23

T. Rowe Price ..... 30

Professional Management, Inc. ..... 10

Read's Drug Stores ..... 106

Reed & Carnrick ..... 22

Roche Laboratories ..... Cover 4, 4-5, 38-39, 92-93

Russel, Marsh & Kennedy, Inc. ..... 106

Manual Schwartz Hearing Rehabilitation ..... 30

G. D. Searle Co. ..... 42-44

Security Business Services, Inc. ..... 38

Special Diet Shop ..... 105

Sterling Lighting Co. ..... 102

Stuart Pharmaceuticals ..... 24-25, 41

Therapeutic Appliances ..... 10

Tio Pepe Restaurant ..... 29

Towson Valley Motors ..... 91

Upjohn Co. ..... 98-100

Van Dyke & Bacon ..... 95

D. Stuart Webb Advertising Services, Inc. ..... 106

White Rice Inn ..... 95

Vera Woods Personnel Service ..... 106

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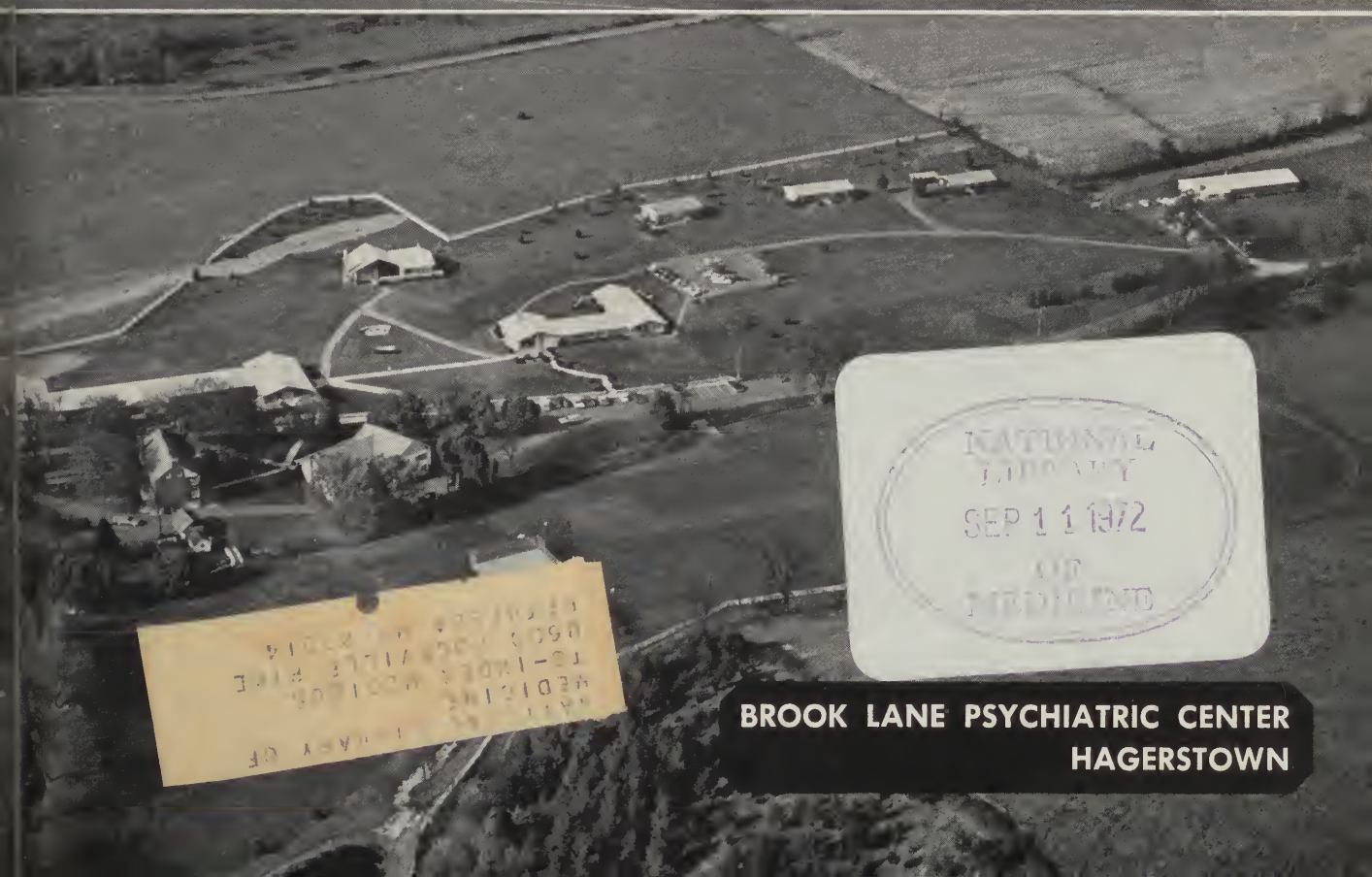
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## ARTICLES:


**Yellow Fever Epidemics of the Late Eighteenth Century in Baltimore** — Douglas Carroll, MD ..... **47**

**Psychiatric Consultations in the Emergency Room** — Jose M. Albornoz-Ruiz, MD ..... **53**

**Arbitration of Medical Malpractice Claims** — James G. Zimmerly, MD ..... **67**

**Lymphocytopenia in Malignant Disease** — Benedict A. Termini, MD ..... **70**


## DEPARTMENTS:


**Baltimore City Health Department — TB Study; Health Aides** ..... **18**

**Woman's Auxiliary—Report of National Convention** ..... **20**

**Heart Page — Treatment of Cardiogenic Shock 1** — Lawrence S. Cohen, MD ..... **26**

**Rehabilitation Medicine — An Approach to Aphasia for the Physician** — Carol D. Rosenfeld, MS; B. Stanley Cohen, MD ..... **30**

**Alcoholism Section — Alcohol-Related Illnesses — Part II** ..... **33**

**Library — 71st Library Association Conference; New Accessions** ..... **37**

**Maryland State Department of Health and Mental Hygiene — An Overview of Tuberculosis in Maryland** — Sterling Bentley ..... **74**

**Maryland Medical Political Action Committee** — Membership, Number One MMPAC Goal ..... **77**

**Emergency Medical Service — Better Staffing, Hospital Emergency Departments** — A. I. Doktorsky, MD ..... **86**



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## MISCELLANY:


AMA Editorial **10**
Doctors in the News **11**
Hospital Salute **12**
New Council Members **13**
Doctors Take Note **14**
Medical News Briefs **15**
Component Societies **19**
Director's Newsletter **23**
Book Reviews **36**
Semiannual Meeting **61**
Sports Seminar **69**
Scientific Exhibits **79**
Info for Authors **90**
Classified Advertising **91**
Advertising Index **92**

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**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

*Usage in Pregnancy.* Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

*Drug Dependence.* There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

*Acute CNS Manifestations.* Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

*Usage in Children.* Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Ambulatory Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

*Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

*CNS Effect.* Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

*Children Under 12 Years of Age.* Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Duration of Therapy.* Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

*Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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First, consider who sets those policies. In a real sense, it is you. You elect the delegates to your state association. They in turn elect the delegates who will represent your views in the AMA House.

As an active, involved member, you can influence policy by making your views known to your delegates, both national and state. It is your democratic right—and responsibility.

Write your delegates, call them, see them. If they aren't responsive, tell them they'll be hearing from you at election time.

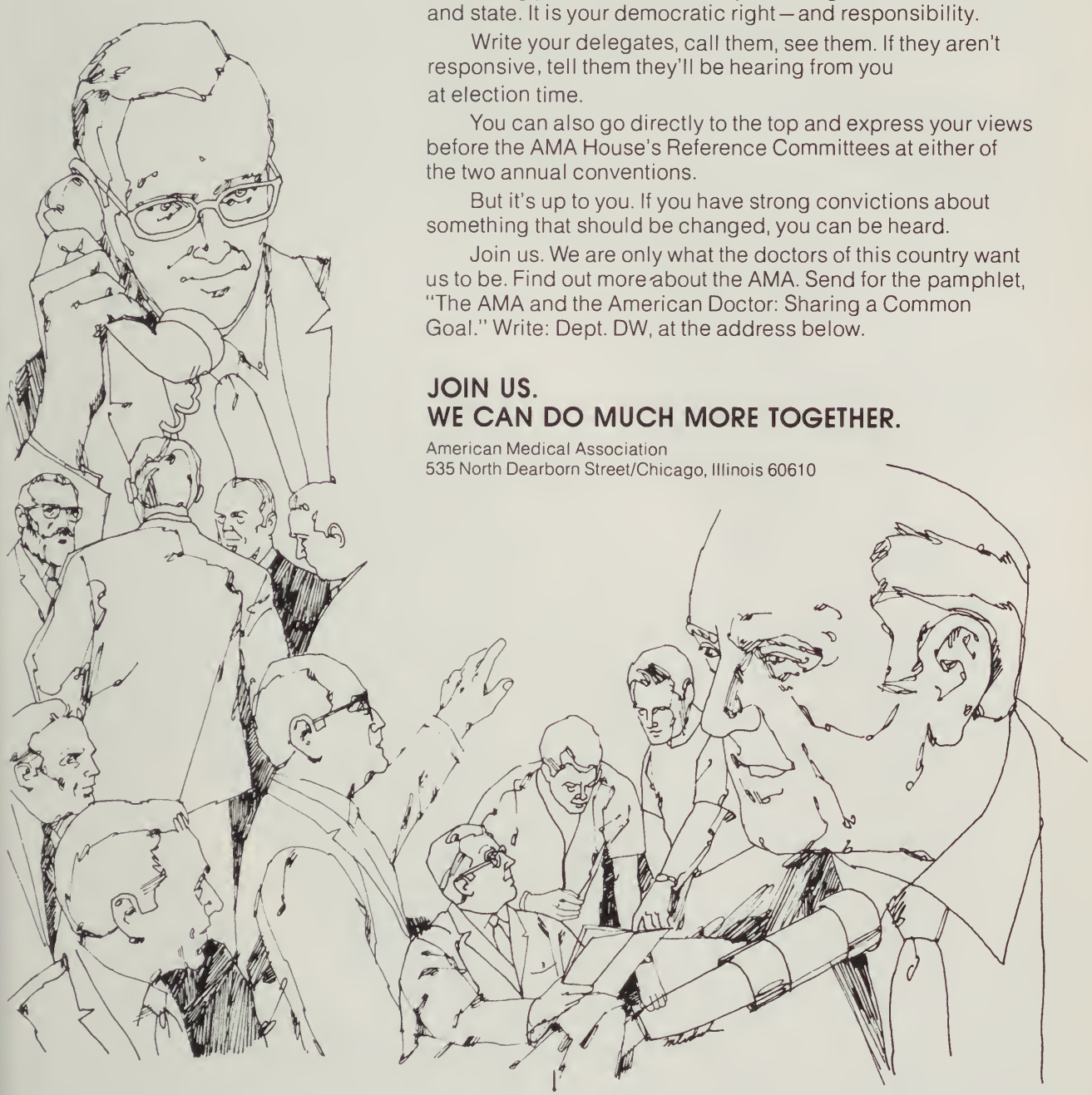
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

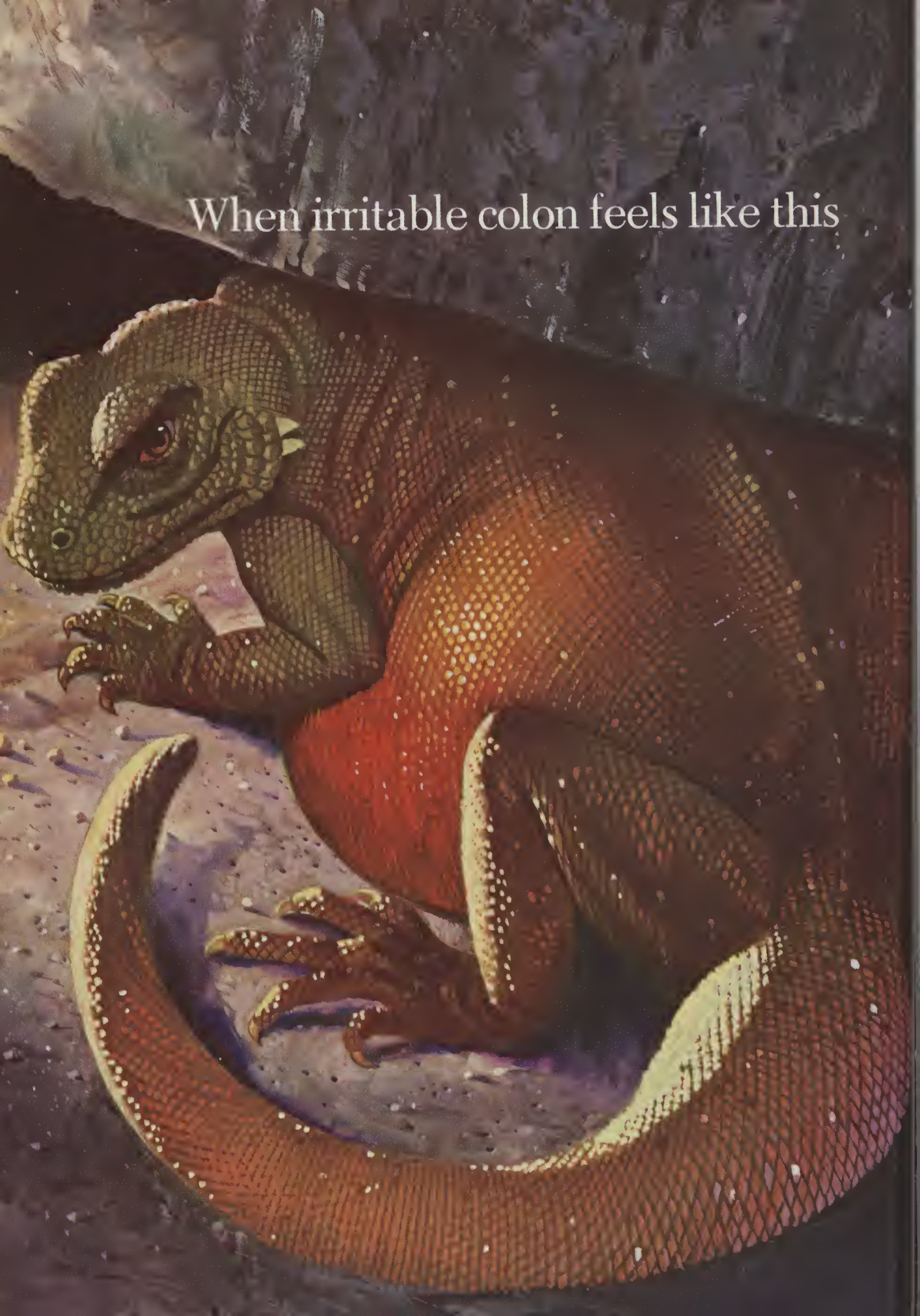
But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

Join us. We are only what the doctors of this country want us to be. Find out more about the AMA. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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**Precautions:** Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

**Side effects:** Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

**Dosage:** *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

*Children 2 to 12 years:* One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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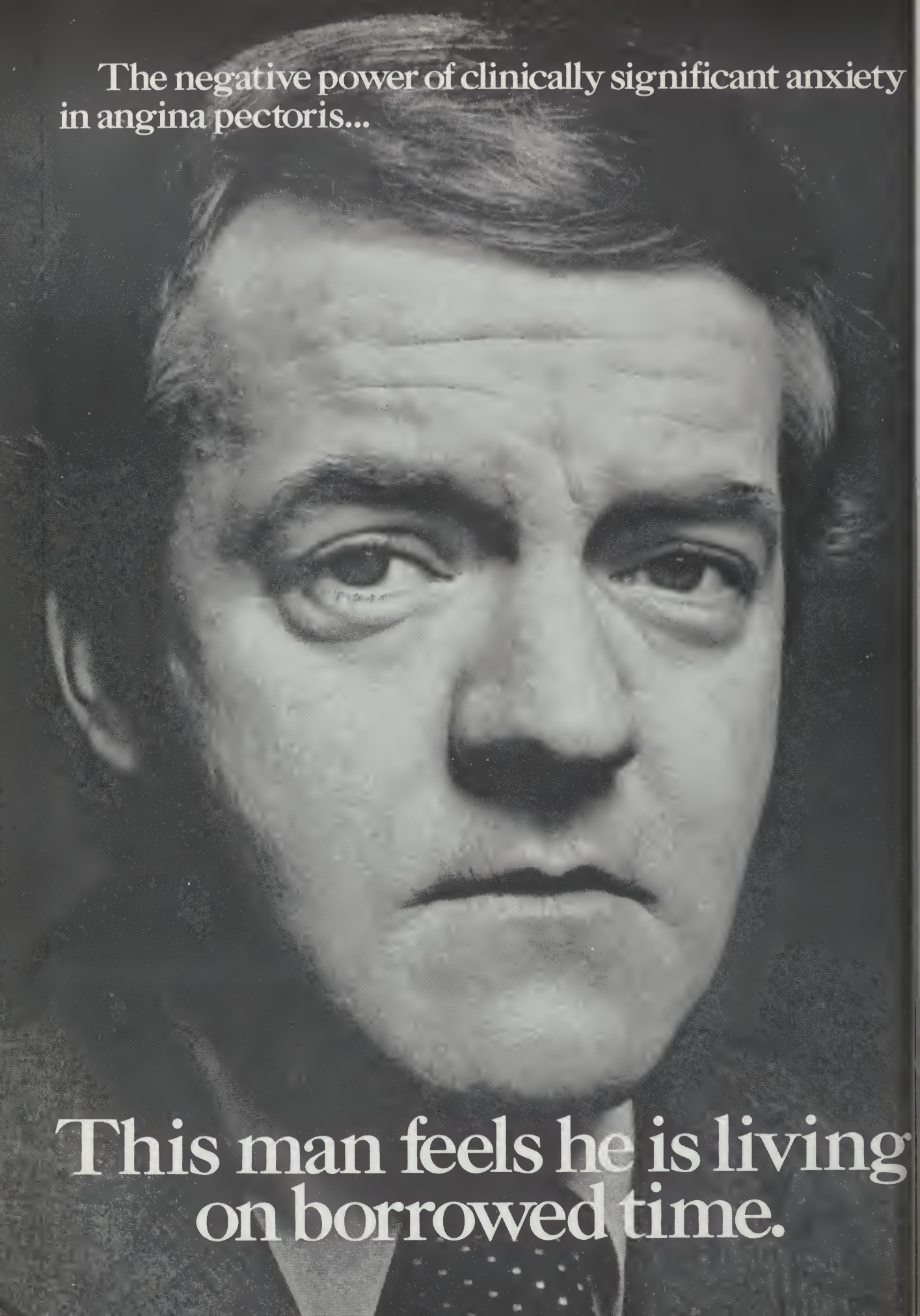
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to move,
and the Latin **sedatus**,
to calm)

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The negative power of clinically significant anxiety in angina pectoris...
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# During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

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*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable* for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

*Librium (chlordiazepoxide HCl) is used concomitantly* with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

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## for moderate to severe anxiety accompanying angina pectoris

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

**A copy of the Levine study may be obtained from your Roche representative.**

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Dear Doctor:

At times many physicians have been critical of the American Medical Association. Occasionally to the extent that they have considered contacting their delegate and letting him have it broadside. But they never did. So they just silently burned.

It occurs to us: how could they expect the AMA to have the foggiest notion of what they were thinking if they didn't tell them?

We think this is where a lot of doctors are missing the boat. They can influence the direction the AMA takes if they'll only get in the boat and start pulling on an oar.

We believe it's time we all reassessed our views about the AMA. The doctors who are the AMA are doing a heck of a job on behalf of all doctors, even though they don't always agree on every matter.

The AMA deserves your support. We can do more together.

Your Delegates to the AMA are interested in your opinions. Our names, addresses, and telephone numbers are listed below. Please feel free to contact us.

Sincerely,

Robert vL. Campbell, MD
145 W. Washington St.
Hagerstown, Md 21740
(301) 739-2911

Russell S. Fisher, MD
111 Penn St.
Baltimore, Md 21201
(301) 752-2000

Charles F. O'Donnell, MD
7501 York Rd
Baltimore, Md 21204
(301) 823-3161

# Doctors in the News

The Board of Directors of the Maryland Division of the American Cancer Society has elected **Edward C. H. Schmidt,** MD, Easton, to serve as president.

Dr. Schmidt is head of the pathology department at Easton Memorial Hospital and also serves on the Editorial Board of the *Maryland State Medical Journal.*

Other officers elected to serve one-year terms as vice presidents include **Raymond P. Srsic,** MD, Severna Park; and **Arthur A. Serpick,** MD, Baltimore.

•

Fourteen Maryland MDs were among a group of 266 physicians who have been made Fellows in the American College of Physicians. The ACP represents specialists in internal medicine and related fields. The new Maryland Fellows include these Baltimore doctors:

**Frank M. Calia**
**Paul J. Davis**
**Charles H. Halsted**
**John Hammann**
**Edward Hinman**
**Esteban Mezey**
**John H. Moxley, III**
**David Simpson**

Others so honored included:

**Peter Frommer,** Bethesda
**Robert C. Young,** Bethesda
**LTC Samuel A. Cucinell,** Edgewood
**Richard E. Smith,** Hagerstown
**Bernard H. Ostrow,** Silver Spring
**Israel Spector,** Silver Spring

•

**William W. Quivers, Sr.,** MD, has been appointed as chief of pediatrics at Baltimore's Provident Hospital. He comes to Baltimore from Winston-Salem, NC.

The AMA Scientific Achievement Award was presented to a Baltimorean at the recent AMA convention in San Francisco.

He is **William B. Kouwenhoven,** professor emeritus of electrical engineering at Johns Hopkins University.

He was presented the highest award the association may confer on someone who is not a doctor of medicine. He was cited for research on the effects of electricity on humans that led to the arresting of ventricular fibrillation by electric countershocks and also for his studies on closed-chest defibrillation.

Dr. Kouwenhoven, now 86, former dean of the Hopkins' School of Engineering, was unable to receive the award in person because of a recent hospitalization.

In 1969 he was granted the only honorary medical degree that the Hopkins has ever awarded.

•

**Andres A. Ramos,** MD, has been named director of the Institute for Children in Owings Mills. It is located on the grounds of Rosewood State Hospital. He was formerly director of Adolescent Services at Springfield State Hospital.

The Institute for Children is the outgrowth of the Esther Loring Richards and Jacob E. Finesinger Children's Centers, opened in 1958 and 1961 to "provide psychiatric and neurotic children with serious emotional, psychiatric, and neurotic illnesses as distinct from those who are mentally retarded."

A native of Puerto Rico, Dr. Ramos has been a member of the staff at Springfield State Hospital since 1966.



**Daniel L. Welliver, MD, Baltimore, was elected president of the Maryland Academy of Family Physicians at their recent annual scientific assembly at Deep Creek Lake, Md. (See story in August Journal.)**

**William R. Newman,** MD, president of the Allegany County Medical Society, reports that eight Allegany County doctors volunteered their services in providing examinations for 530 Girl Scouts who attended summer camps this year.

•

The following Marylanders, all MDs, were recently certified as Diplomates of the American Board of Anesthesiology:

**William L. Cole,** Bethesda
**Bruce F. Cullen,** Bethesda
**Gary J. Healy,** Suitland
**Kwangwon Kang,** Aberdeen
**Jae-Koo Kim,** Bethesda
**Ey Kol Koh,** Timonium
**Harmon C. Landesman,** Baltimore
**Jordan D. Miller,** Silver Spring
**Alicia B. Radice,** Bethesda
**John P. Swope,** Bethesda
**James R. Tyler,** Silver Spring

The first female chief resident at the Johns Hopkins Hospital was awarded the Knight of the Order of Leopold by her native Belgium in recent ceremonies at the residence of the Belgian ambassador to the United States.

**Ghislaine D. Godenne, MD,** now an associate professor of pediatrics and psychiatry at Hopkins, was honored for her service to Belgians living in this country and for numerous achievements in medicine.

From a story in the County Record (Denton, Md), we learn that **William A. Anderson, MD,** retired from the practice of medicine there on July 1.

Dr. Anderson's retirement was forced, he explained, by reasons of complications of serum hepatitis.

He had rounded out 35 years of practice after graduation from Hahneman Medical College in Philadelphia in 1937.

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Med-Chi Salutes

## BROOK LANE PSYCHIATRIC CENTER

Brook Lane Psychiatric Center, Hagerstown, Md, is a private not-for-profit facility providing comprehensive mental health services to western Maryland and adjoining counties in Pennsylvania and West Virginia.

It maintains a 40-bed inpatient hospital, with both adolescent and adult programs; outpatient services; partial hospitalization; both day and night care; emergency admissions; and a wide range of consultative and educational relationships.

It is oriented toward community mental health and works closely with the Washington County Department of Health in the delivery of mental health care. There are training affiliations in psychiatric nursing, occupational therapy, and in clinical pastoral education.

Special programs include perceptual motor dysfunction, psychodrama, music therapy, and a newly established nonclinical Growth Services Center directed toward various areas of professional and personal growth and counseling.

Brook Lane is one of six hospital centers affiliated with Mennonite Mental Health Services. Edmund V. Niklewski, MD is medical director; Wesley W. Oswald is the administrator.

**Jane E. Mahaffey, MD,** Department of Medicine, University of Maryland School Medicine, has been awarded a research project grant by the Southern Medical Association.

The grant will help to fund Dr. Mahaffey's project, Mechanism of Action of Hypomagnesemia in the Stimulation of Parathyroid Secretion.

The Research Project Fund, established in 1969, is one of several SMA programs that support the organization's exclusive purpose of developing and fostering scientific medicine.

•

**Leslie Roy Miles, Jr., MD,** Lonaconing, has been ordained by Bishop Harry L. Doll of the Episcopal Church under their new Canon permitting ordination of highly educated and faithful Churchmen in isolated communities.

•

The recipient of the four-year premed scholarship awarded this year by the Washington County Medical Society was Terrence Campbell of Hagerstown. He will attend Duke University. Pictured with him in the related *Hagerstown Daily Mail* story was **Ralph Williams, MD,** president of the Society; and **Lloyd A. Hoffman, MD,** chairman of their scholarship committee.


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# MEET YOUR NEW COUNCIL MEMBERS

Carolyn H. S. Pincock, MD, of Montgomery County, was elected in a dual capacity at the 1972 Annual Meeting of the Faculty. She assumed office as a councilor at the conclusion of the 1972 annual session and takes office as first vice president at the conclusion of the 1973 annual session. Dr. Pincock was elected for a one-year term on the Council to fill a vacancy created by the continued growth of members of the South Central District.

A Montgomery County pediatrician with offices at 14602 Edelmar Dr in Silver Spring, Dr. Pincock brings a wealth of experience into her new Med-Chi offices.

Her husband, Glen, whom she married in 1934, is also a doctor and is in general practice at 3604 Cardiff Rd in Chevy Chase.

They have three children: David, a CPA; Dianne, a graduate of the School of Nursing of the Washington Hospital Center; and Douglas, a Rockville pedodontist. Their six grandchildren are the source of much pride and joy.

She was born Oct 9, 1910 at Kingston, NY, and christened Carolyn Hannah Snyder. Her father, the late Rev. Howard Elias Snyder, was for 22 years pastor of Washington's Atonement Lutheran Church.

After attending elementary schools in Kingston, Madison (Wisc), and Philadelphia, she graduated from Central High School in Washington in 1927.

She attended the University of Wisconsin and George Washington University from where she received her BA in 1931 and MD in 1934.

A junior internship at Kingston General Hospital in 1933 was followed by a 1934-1935 general internship at George Washington University Hospital. She was in pediatric residency at Children's Hospital in Washington in 1935 and 1936.

Other Children's Hospital connections included: OPD Luetic Clinic, 1936-1955; Adolescent Clinic, 1955-1964; associate attending staff, 1936-1968; attending advisory staff, 1968-1971; and alumni association vice president, 1953.

From 1935 to 1940 she was employed by the District of Columbia Health Department's Division of Maternal and Child Health. And from 1940 to 1946 she served as instructor in pediatrics at the George Washington University.

She currently has courtesy staff privileges at the Washington Hospital Center and Providence, Columbia, George Washington University, Sibley, Suburban, and Holy Cross hospitals; also the Washington Sanitarium and Hospital.

She is a member of Branch One, American Medical Women's Association and served as secretary in 1939-1940 and as president in 1949-1950.

She was AMWA resolutions chairman, 1964-1965; councilor, 1966-1968; second vice president, 1968-1969; and first vice president, 1968-1971. She was also honored as their 1956-1957 Woman of the Year.

In addition to AMA and Med-Chi membership, she was a member of the District of Columbia Medical Society from 1939 to 1968 where she had two terms as second vice president (1943-1944 and 1947-1948).

An active member of the Montgomery County Medical Society since 1955, she was president in 1970, vice president in 1969, and secretary in 1965-1966.



**Dr. Pincock**

In December 1956 she was signally honored by McCall's Magazine with their Togetherness award.

She was the 1970 recipient of the Henry P. Laughlin Award of Adolescent Medicine.

Among her other memberships are these: Alpha Epsilon Iota, women's national medical sorority; Prince George's and Montgomery counties Pediatric Society, past president; American Academy of Pediatrics, Maryland Chapter; Daughters of the American Revolution, Potomac Chapter; Daughters of Colonial Wars; and Business and Professional Women, 1950-1951 state chairman, health and safety.

She is on the Board of Directors of Takoma Park's Cynthia Warner School, served on the George Washington University Medical School's Alumni Council from 1968 to 1971, and was president of the GWU Women's Glee Club under Robert H. Harmon, MD.

So, look for things to really hum during the Faculty tenure of this really remarkable woman!

# Doctors take note...

## MARYLAND AREA MEETINGS

| | | |
|---|---|---|
| Oct | 6 | **Children's Med & Surg Cen, Johns Hopkins Univ**, Baltimore. Progress in Pediatrics 1972. Clinical program & PM banquet. Contact: Matthew Debuskey MD, CMSC 2-124, Johns Hopkins Hosp, Baltimore Md 21205. |
| Oct | 20-22 | **Heart Assoc of Md,** 25th anl mtg, Hunt Valley Inn, Md. Contact: Heart Assoc of Md, 201 N Charles St, Baltimore Md 21201, phone (301) 539-0818. |
| Nov | 4 | **ACP 3-State Regional Mtg** (Md-Del-DC), Howard Univ, Washington DC. Contact: Henry C Ecker MD, 916 19th St NW, Washington DC 20006. |
| Nov | 13-16 | **Interstate Postgrad Med Assoc of North America,** 57th Anl Scientific Assembly, Washington-Hilton Hotel, Washington DC. Primarily for family physicians & internists. $25 fee, 26 hrs instr. Contact: Alton Ochsner MD, IPMA, PO Box 5445, Madison Wisc 53705. |
| Dec | 2 | **6th Anl Medical Aspects of Sports Seminar.** Sponsors: Med-Chi & Catonsville Community College, Baltimore. |
| Apr | 25-27 | **Med-Chi 175th Anl Mtg,** Civic Center, Baltimore. |

## AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

| | | |
|---|---|---|
| Sep | 25-29 | **Basic Mechanisms in Internal Medicine,** Med Col of Virginia, Div of Hlth Sciences, Richmond. |
| Oct | 2-4 | **Current Concepts in Hematology,** Univ of Pittsburgh, Pittsburgh. |
| Oct | 2-4 | **Developmental Biology & Perinatal Medicine,** McGill Univ, Montreal. |
| Oct | 2-6 | **NonMedical Use of Drugs: Challenge to Physician,** New Jersey Col of Med, Newark. |
| Oct | 9-11 | **Advances in Therapeutics & Clinical Pharmacology,** Reitz Union, Univ of Florida, Gainesville. |
| Oct | 9-12 | **Human Reproduction, Population Problems & Fertility Control,** Harvard Med Sch, Boston. |
| Oct | 12-14 | **Recent Advances in Infectious Diseases,** Mayo Mem Aud, Univ of Minnesota, Health Sciences Cen, Minneapolis. |
| Nov | 6-8 | **Current & Future Concepts in Gastroenterology,** Univ of Arizona Col of Med, Tucson. |
| Nov | 8-10 | **Internal Medicine Grand Rounds,** Mayo Clinic, Rochester, Minn. |

## AMERICAN COLLEGE OF CHEST PHYSICIANS

(Contact ACCP, 112 E Chestnut St, Chicago Ill 60611 for info.)

| | | |
|---|---|---|
| Sep | 21-23 | **Coronary Artery Disease 1972,** Page & Wm Black Postgrad Sch of Mt. Sinal Sch of Med, New York City. |
| Oct | 5 | **Cardiopulmonary Nursing,** Hertzler Research Foundation, Halstead Hosp, Halstead Kan. |
| Oct | 23 | **38th Anl Scientific Assembly,** Denver. |

## MISCELLANEOUS MEETINGS

| | | |
|---|---|---|
| Oct | 14-19 | **American Academy of Pediatrics,** 41st Anl Mtg, New York Hilton Hotel, New York NY. Contact: AAP, 1801 Hinman Ave, Evanston Ill 60204. |
| Oct | 25 | **NY State Action for Clean Air,** 8th Anl Symposium on Environment & Hlth, Hotel Syracuse, Syracuse. Contact: NYSACA, 105 E 22nd St, New York, NY 10010. |
| Oct | 27-28 | **Peripheral Arterial Symposium,** Philadelphia. Sponsor: Temple Univ Hosp. Contact: Dept of Rehab Med, Temple Univ Health Sciences Cen, 3400 N Broad St, Philadelphia Pa 19140. |
| Nov | 24-25 | **Conf on Radiology in Otolaryngology & Ophthalmology,** Chicago. Sponsor: Abraham Lincoln Sch of Med, Univ of Illinois Med Cen. Contact: GE Valvassori MD, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680. |

# Medical News Briefs



BOYS TOWNERS—Pictured at announcement of the new Boys Town Institute, from the left, were: Patrick E. Brookhouser, MD, Baltimore; Archbishop Daniel E. Sheehan, president of the Board of Directors of Father Flanagan's Boys' Home; and John E. Bordley, MD, Baltimore.

## Boys Town Institute Taps 2 Baltimore MDs

A Boys Town Institute for the Study and Treatment of Hearing and Speech Disorders in Children is being established in Boys Town, Nebr at an estimated cost of $30 million.

Director of the Boys Town Institute will be Patrick Brookhouser, MD. Senior Consultant will be John E. Bordley, MD. Both men acted as consultants in the design and initial development of the project. Both are recognized in the field of communicative disorders.

Dr. Bordley is emeritus Andelot professor of laryngology and otology of the Johns Hopkins University School of Medicine.

He serves as executive director of the American Council of Otolaryngology; is a past president of the American Otological Society; and director of the Information Center for Hearing, Speech, and Disorders of Human Communication, also at Johns Hopkins.

Dr. Brookhouser is in the Department of Otolaryngology at the Johns Hopkins School of Medicine; is scientific consultant to the Information Center for Hearing, Speech, and Disorders of Human Communications at the Hopkins; and is currently serving as a member of the Medical Board of the Johns Hopkins Hospital.

The Boys Town Institute will consist of two facilities. One will be located on the Boys Town campus and the other will be a part of the Criss Institute for Health campus at Creighton University in Omaha.

The two facilities include an Institute for the Study and Treatment of Hearing and Speech Disorders in Children and a Department of Otolaryngology, Maxillofacial Surgery, and Communication Sciences.

A home-type facility for the care and housing of some 50 communicatively handicapped boys and girls will be constructed on the Boys Town campus.

There will also be a Model School Facility for approximately 50 students, including some day students from Omaha and vicinity.

A 50-bed facility will be built on the Criss Institute campus. It will include a comprehensive diagnostic center for hearing and speech disorders, as well as facilities for medical-surgical rehabilitation of communicatively handicapped children.

The boy and girl patients will be admitted through a selection committee according to such criteria as a) inability to afford care at other institutions, b) potential for rehabilitation, and c) suitability of the particular communication handicap for inclusion in on-going teaching and research programs.

## Orthomolecular Medicine

The winner of two Nobel prizes, Linus C. Pauling, MD, explained his theories of orthomolecular medicine in a talk at the University of Maryland at Baltimore recently.

As guest of the department of cell biology and pharmacology of the School of Medicine, Dr. Pauling gave the annual John C. Krantz, Jr. Lecture.

The Krantz Lecture was initiated three years ago to honor John C. Krantz, Jr., MD, upon his retirement as chairman of the pharmacology department of the medical school.

A professor of chemistry at Stanford University, the 71-year-old Pauling has been the center of an ongoing controversy since publication two two years ago of his book *Vitamin C and the Common-Cold,* in which he maintains that massive doses of Vitamin C can prevent or alleviate colds.

## TB Program Initiated

In a move to provide Marylanders with the most effective protection against tuberculosis, Neil Solomon, MD, secretary of Health and Mental Hygiene, announced that a three-fold plan to find new cases of the disease has been initiated.

The preventive program, which has been evolving since 1969, incorporates tuberculin skin testing of high-risk groups, X-raying those persons showing a positive reaction, and referring for further diagnosis and treatment those showing a positive skin test and a suspicious X-ray.

This program, according to Dr. Solomon, replaces the "community surveys," in which mobile X-ray units traveled the state X-raying any citizen who walked into the facility.

"We have found," he said, "that such surveys no longer provide the most effective means of finding new cases of tuberculosis. In the past it has taken as many as 4,323 X-rays statewide to find one active case.

"We have, therefore, decided to phase out one of our two mobile units between now and Dec 31, 1972. The one remaining unit will be used to screen those persons showing a positive reaction to the tuberculin skin test," Dr. Solomon continued.

The new procedure calls for a team of respiratory disease and local health personnel to perform skin tests on high risk groups. The mobile unit will be stationed at the test site when the team returns to read the skin test results, and will immediately X-ray those with a positive reaction.

The secretary emphasized that Maryland's program conforms with HEW's Food and Drug Administration requirements for continued use of the mobile X-ray equipment: a physician trained in chest X-ray analysis interprets all films; records are maintained for at least five years; the equipment is checked annually by the Environmental Health Administration's Division of Radiological Health to insure that it meets required Federal and State specifications; and full follow-up treatment is available.

Screening programs may be initiated in specific areas by a local health department contacting a high-risk group in the community, by a group contacting the health department, through a labor organization request, or through a local tuberculosis association.




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## Steamed Crabs Advice

So that Marylanders may safely enjoy the uniquely and internationally famous pleasure of devouring steamed crabs, Neil Solomon, MD, Maryland's secretary of Health and Mental Hygiene, recommends that certain common-sense precautions be followed in preparing them.

Live crabs need not be refrigerated, but proper chilling can increase the out-of-water life. Crabs are required to be alive when cooked.

Live crabs and cooked crabs should not be kept in the same storage area unless there is a moisture tight barrier between them and also between any other food products.

Baskets used to hold live crabs, once emptied, shall not be used to hold cooked crabs.

For cooking crabs at home, use a pot large enough to hold the crabs. As part of the pot there must be a false bottom (perforated) which will provide two to three inches of space for the liquid. The liquid must be brought to a "rolling boil." Crabs are placed on the false bottom and condiments sprinkled onto the crabs, then steamed for 30 minutes. Salt, peppers or other spices must be added only before steaming. Poor crabs (buckrams), however, need to be cooked longer than "fat" crabs.

To maintain an acceptable quality, crabs must be refrigerated within three hours after cooking. If refrigerated, they should be kept at 45 degrees or less.

All efforts to produce a crab safe to eat can be lost if the crabs are allowed to come into contact with any surface or container that the uncooked crabs were kept in. While the crabs are cooking, areas where the crabs were being stored or prepared should be cleaned and sanitized. Sanitizing can be done by using two tablespoons of ordinary household laundry bleach in one gallon of water applied with a cloth in a daubing operation.

Dr. Solomon said that all county health officers and the seafood industry have been provided with guidelines for the proper handling and cooking of crabs.

## Clinical Engineering

The Johns Hopkins Hospital has established a new clinical engineering division, directed by J. B. Oakes, to apply modern engineering science and technology to appropriate hospital problems.

Richard J. Johns, MD, director of Hopkins' biomedical engineering department, said the division, a part of his department, will work in a number of areas to help the hospital provide more effective patient care.

According to Mr. Oakes, the division is an outgrowth of the hospital's Clinical Engineering Task Force, established in March 1971 to evaluate the need for, and the approach to, the application of engineering principles to hospital problems.

The task force focused attention on several problem areas, he said, particularly on developing engineering specifications for acquiring an electronic patient monitoring system for the hospital's new intensive care unit.

This monitoring system allows vital signs such as electrocardiograms, blood pressure, and respiratory function to be displayed in the patient's room, and simultaneously in a central nurses' station. An automatic alarm system is also available for additional patient protection.

Mr. Oakes said other clinical engineering tasks related to the monitoring system included acceptance testing of each component and of the installed system, establishment of preventive maintenance and repair procedures, and training medical personnel to use the system.

## Ambulatory Services

The first complete guide to ambulatory services offered at the University of Maryland Hospital is now being distributed at selected clinics on a trial basis.

The brightly colored booklet will be given to all of the hospital's outpatients and contains six insert cards describing all of University Hospital's ambulatory services. It offers specific details, such as clinic hours and phone numbers, on all clinics in the Outpatient Department Building, all services of the Community Pediatric Center, psychiatric outpatient services, clinics outside the Outpatient Department Building, information about the Emergency Room, all resources for all alcoholism and drug services, and information about social work and medical assistance.

Designed as a permanent guide to the patient, the "Guide to Ambulatory Services" also lists emergency telephone numbers and has a pocket for patients to keep their appointment cards for future clinic visits. It is to be brought to all clinic visits.

In addition to on-campus distribution at the University of Maryland at Baltimore, the guide will be distributed at selected community agencies under the auspices of the Ambulatory Services Committee of the Medical Board of University Hospital.




ROBERT E. FARBER, MD, MPH, Commissioner

# Baltimore City health department

## TUBERCULOSIS–HOME AND HOSPITAL STUDY

The Baltimore City Health Department's Division of Tuberculosis in conjunction with Elmer P. Sauer, MD, medical superintendent at Mount Wilson State Hospital; and Richard L. Riley, MD, chairman and professor of Environmental Medicine, the Johns Hopkins University, has begun a study to compare the effects of drug therapy on active tuberculosis cases and their families when treatment is carried out in hospital and at home.

Similar studies have been carried out in other countries and these have established beyond doubt that home treatment is just as good and as safe as treatment in a hospital. Some doubt has been cast on these studies on the grounds that both the infecting agent and the patients are different.

The object of the study is to determine on a purely local basis whether or not it is necessary to subject tuberculosis patients, who are otherwise well, to a prolonged incarceration in a hospital, and at the same time to establish if the extra effort required to maintain patients on drugs at home costs significantly less than treatment in hospital.

The study could result in substantial savings which would increase with the rising costs of hospital treatment. Unfortunately, however, by reason of the present method of budgeting, any savings earned would not accrue to the City program, but at least it would be hoped that the patients would benefit.

The program will be conducted on the normal operating budget of the health department's tuberculosis division with support from the National Tuberculosis and Respiratory Diseases Association, administered through the Maryland Tuberculosis Association.

## Health Aides Available

A class of 28 Health Aides has completed intensive class and field studies in basic personal and community health in the Baltimore City Health Department Health Aide Training Program based in the Southern Health District Building, 1211 Wall St. The newly certified Health Aides are available and qualified for work as school health aides, social work aides, nursing home aides, hospital or physician clerical duties, and similar activities. Physicians and dentists or health and social welfare agencies needing assistance that may be accomplished by Health Aides may call Mrs. Nancy McAndrew, RN, supervisor of Health Aide Training, phone 727-3471.

The Health Aide Training Program for unemployed or under-employed city residents is funded for a six-month period by the Manpower Development Training Act through the Baltimore City Community Action Agency's Concentrated Employment Program. Assisting agencies include the City and State Departments of Education and the Maryland State Employment Service.

The next class will begin on a date to be set in September. The Health Aide Training Program is directed by Mr. Raymond M. Puryear, Social Worker Consultant in the Baltimore City Health Department.

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**Journal Representative**

# Baltimore City Medical Society

**At its monthly meeting on June 6, 1972, the Board of Directors took the following actions:**

1) Invited the chairman of the Membership Committee to the next meeting to discuss the status of interns and residents in the Society.

2) Referred, on recommendation of the chairman of the Peer Review Committee, a case wherein the Society was unable to obtain a physician's records to the State Peer Review Committee.

3) Approved the Committee to Review Research Protocols recommendation that the Society endorse the Breast Cancer Detection Project proposed by R. Robinson Baker, MD.

4) Approved the recommendation of the Finance Committee to place the present part-time office employee on full-time status.

5) Approved the recommendation from the Committee on Drugs that a letter be sent to the FDA and BNDD urging that Methaqualone not be placed on the BNDD's Schedule 2 of restricted drugs.

6) Approved Emeritus Membership for William Garlick, MD.

7) Received the report of the AMA Public Affairs Survey, conducted from March 27 to March 29.

**The Board of Directors met on July 11, 1972, and the following actions were taken:**

1) Heard a report from D. Frank Kaltreider, MD, chairman of an ad hoc committee to consider ethical standards of advertising for physicians. The Board voted to request the Medical and Chirurgical Faculty to consider the problem of advertising by groups other than those sponsored by third-party payors. Some members suggested the possibility that the Baltimore City Medical Society might establish some listing of physicians by neighborhoods for distribution throughout the city.

2) Approved the request of the Committee on High School Athletics that a letter be sent to the membership requesting physicians to volunteer to cover high school football games played in the city schools during the ten-week season in the fall.

The Board also approved the recommendation that a course in the care of athletes be sponsored by the BCMS and presented to the coaches of all high school teams in the city public school system. The Board requested the committee to develop a comprehensive medical care program for high school athletes which could be proposed to the school board in the future.

3) Referred the AMA Public Affairs Survey to the Policy and Planning Committee for detailed review and report.

4) Heard a report on the meeting of Metropolitan Medical Society held in San Francisco on June 17 from Philip F. Wagley, MD. The report was referred to the Policy and Planning Committee for consideration.

5) Opposed City Council Bill 373 which would establish a mechanism for physicians to obtain a parking sticker for a fee of $10 which would be used in certain parking areas around hospitals.

6) Referred City Council Bill 394 dealing with the disposition of syringes and hypodermic needles to the Committee on Drugs for an opinion.

7) Approved the recommendation of the Finance Committee that $10,000 be invested in T. Rowe Price New Era Fund.

8) Recommended Emeritus Membership for Florence I. Mahoney, MD.

9) Agreed to submit names to the Mayor's office for the purpose of establishing a committee to develop medical standards for the Baltimore City Jail.




MRS. ROBERT A. REITER, Editor

woman's auxiliary

# Report of the 49th Annual Convention of the Woman's Auxiliary to the AMA

The 49th Annual Convention of the Woman's Auxiliary to the AMA opened on June 18, 1972 in San Francisco. In an unprecedented move the AMA House of Delegates turned over the first hour of their opening session to the women, and in a joint session special tribute was paid to the Woman's Auxiliary, highlighting their 50th Anniversary Convention.

The program featured an audio-visual, multimedia presentation preceded by a musical tribute to the MDs to the tune of "Mame" and a 1920s style show by eight Auxiliary models. The film sketched the highlights of 50 years of achievement for the Woman's Auxiliary.

During the meeting Wesley Hall, MD, presented a citation to Mrs. G. Prentiss Lee, and 50 roses were presented to Mrs. Robert Beckley by C.A. Hoffman, MD. In addition, Mrs. Lee presented a check for $740,388 to John M. Chenault, MD, president of the AMA-ERF. This check marked the Auxiliary's largest single contribution. Since 1951 the Auxiliary has raised $5,487,399 for AMA-ERF, which provides unrestricted grants to medical schools and enables medical students, interns, and residents to obtain loans.

Your Maryland Delegation included the following: Mrs. Marvin L. Kolkin, president; Mrs. Leslie R. Miles, Jr., president-elect; Mrs. John N. Robinson, first vice president; and Mrs. H. Leonard Warres. Several other members of our state auxiliary attended this convention.

Some 1,339 registrations and standing room only at the opening business session on Monday would certainly seem to indicate a great amount of interest and enthusiasm in our national auxiliary.

A resolution for safety on the streets was passed, making this a priority project for the Auxiliary and implementation throughout the membership was recommended.

Amendments passed at the national level made the president-elect chairman of the Committee on Program Development, and the treasurer a member of the Committee on Philanthropy. Others restructured the finance and program development committees.

Guest speaker at the annual luncheon honoring AMA officers, trustees, and their wives was Art Linkletter, who spoke on "Changing Patterns in Drug Abuse." Mr. Linkletter stated that not only do we have a drug problem, but also a people problem. We are all guilty, though unconsciously so, of contributing to the drug problem. Auxiliary wives were advised: "Use a little pillow talk to remind your husbands that they have a huge responsibility every time they prescribe a psycho-active drug. Too often doctors forget that a person, especially a young person, can get hooked on that very prescription." Mr. Linkletter urged the Auxiliary members to campaign for realistic drug education in the schools, starting in kindergarten, and to launch a drive to have hospitals make room for addicts, and treat them like sick people, not criminals.

Our Maryland delegation and guests were proud indeed to have Elizabeth Linhardt, state AMA-ERF chairman, accept an award on behalf of our Auxiliary. Maryland was one of eight states to contribute over $20 per capita to the AMA-ERF Fund. We were fourth in the country in that category thanks to the never-ending and dedicated efforts of Mrs. Linhardt.

At Tuesday's meeting Victor Weingarten, director of the President's Committee on Health Education, spoke on "The Role of the Woman's Auxiliary in Health Education." "Health Education has a low priority in schools," he stated, and our Woman's Auxiliary represents what could be a major effort at a community level to

carry on where literature leaves off. Be an example—even to what you eat! Start health education in day care centers, clubs, etc., and work on patient health education through your hospital auxiliaries. Have pilot demonstrations on health education and work on getting rid of legislative impediments concerning health problems. Mr. Weingarten feels that all of these are worthwhile projects for auxiliaries to undertake in an effort to lessen the ignorance, inertia, and indifference of many people.

Edward J. Stainbrook, MD, PhD, head of the Human Behaviour Department of the University of California School of Medicine, thinks that the Auxiliary can be a tremendous force in changing the education system. "You must stop being so concerned with changes in the exterior world and stop neglecting your interior world—your community. Schools should be concerned with teaching how to get along with people, not just instruction in subjects and skills," he said.

An idea exchange presented by the state presidents was an informative way to hear the highlights of each state auxiliary. These sessions were an inspiration to each auxiliary delegation to return to their home state and try to promote even bigger and better projects.

At the closing meeting on Wednesday, June 21 our Maryland Auxiliary received another award. Caryl Kolkin accepted a membership merit award for the organization of a new county. Welcome Anne Arundel County, and thanks for making it possible for Caryl to bring home another award!

In her AMPAC report to the Auxiliary Mrs. John M. Chenault, chairman, asked that we try to increase membership in AMPAC. Also, in this an election year, all auxiliaries should be working on candidate and delegate support for those who will back acceptable bills through their legislative committees and other volunteer activities.


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Mrs. Robert F. Beckley was installed as president of the national auxiliary at this meeting. Her inaugural address outlined the three main objectives upon which the Auxiliary was founded. She reviewed what has been done in the past year, and how we can continue to meet the challenges which lead to the achievement of those original objectives. She stated that each auxiliary should study local needs and develop plans for meeting these needs. "We must try to achieve our dreams. We must become effective persuaders. We must believe that health education is the key to quality of life," says Mrs. Beckley.

Other excellent reports, a fabulous style show of oriental fashions, two very lovely receptions, another opportunity to meet fellow Auxiliary members from all parts of the country, and to share their comradeship and views all were instrumental in making this 50th Anniversary Convention one long to be remembered as outstanding, informative, and vitally stimulating to those of us who were privileged to be there.

DONNA MILES
Chairman of the Delegation

**MARYLAND AMA-ERF CONTRIBUTIONS**

**JUNE 1, 1971 THRU MAY 31, 1972**

| County | Faculty | | Auxiliary |
|---|---|---|---|
| | $ | | $ |
| Allegany | 635.00 | | 368.07 |
| Baltimore City | 4,504.46 | | 652.82 |
| Baltimore County | 1,345.00 | | 290.59 |
| Carroll | 285.00 | | 37.83 |
| Cecil | 140.00 | | 9.04 |
| **4-County** | | | |
| Caroline | | | |
| Kent | 150.00 | | |
| Queen Anne | 20.00 | | 1,108.08 |
| Talbot | 400.00 | | |
| Harford | 175.00 | | 1,373.87 |
| Montgomery | 2,885.00 | | 1,580.43 |
| Prince George's | 1,255.00 | | 519.99 |
| Washington | 245.000 | | 101.10 |
| Wicomico | 545.00 | | 1,035.65 |
| **Members-At-Large** | | | |
| Anne Arundel | 570.00 | | |
| Calvert | 10.00 | | |
| Charles | 180.00 | | |
| Dorchester | 90.00 | | |
| Frederick | 360.00 | | 407.92 |
| Garrett | 75.00 | | |
| Howard | 200.00 | | |
| St. Mary's | 40.00 | | |
| Worcester | 30.00 | | |
| Unlisted, At-Large | 1,675.00 | State | 653.87 |
| | $ 15,814.46 | | $ 8,139.26 |

**Grand Total:** $ 23,953.72

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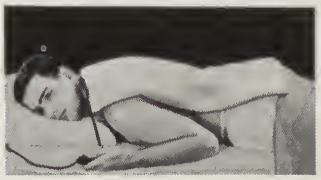
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# executive director's newsletter

September 1972

MALPRACTICE ALERT

Physicians are again advised to ensure they are talking to agents representing their own professional liability (or other) carrier when discussing cases involving them. Instances have occurred where investigators have identified themselves as representing the insurance carrier without specifying which one.

This can oftentimes lead to embarrassment for all concerned but, more important, can involve the physician in situations that could work to his disadvantage.

DEMOCRATIC HEALTH PLATFORM

The Democratic Party has adopted the following health plank as part of its platform:

..... "Establish a system of universal National Health Insurance which covers all Americans with a comprehensive set of benefits including preventive medicine, mental and emotional disorders, and complete protection against catastrophic costs, and in which the rule of free choice for both provider and consumer is protected. The program should be federally-financed and federally-administered. Every American must know he can afford the cost of health care whether given in a hospital or a doctor's office.

..... "Incorporate in the National Health Insurance System incentives and controls to curb inflation in health care costs and to assure efficient delivery of all services.

..... "Continue and evaluate Health Maintenance Organizations.

..... "Set up incentives to bring health service personnel back to inner-cities and rural areas.

..... "Continue to expand community health centers and availability of early screening diagnosis and treatment.

..... "Provide federal funds to train added health manpower including doctors, nurses, technicians, and para-medical workers.

.....“Secure greater consumer participation and control over health care institutions.

.....“Expand federal support for medical research including research in heart disease, hypertension, stroke, cancer, sickle cell anemia, occupational, and childhood diseases which threaten millions and in preventive health care.

.....“Eventual replacement of all federal programs of health care by a comprehensive National Health Insurance System.

.....“Take legal and other action to curb soaring prices for vital drugs using antitrust laws as applicable and amending patent laws to end price-raising abuses, and require generic name labeling of equal-effective drugs.

.....“Expand federal research and support for drug abuse treatment and education, especially development of non-addictive treatment methods.”

PROFESSIONAL LIABILITY RATES

Recent information received by the Faculty indicates a widening spread in insurance rates between Maryland and some other states. (all for $100,000/300,000 coverage):

| | Maryland | NY | Calif | DC | National Average |
|---|---|---|---|---|---|
| Class I | 239 | 625 | 915 | 325 | 277 |
| Class II | 419 | 1393 | 1603 | 575 | 493 |
| Class III | 907 | 3130 | 3470 | 1250 | 1059 |
| *Class IV | 1210 | 4305 | 4627 | 1660 | 1423 |
| Class V | 1512 | 4377 | 5783 | 2050 | 1786 |

Arizona, in Class IV, has a rate of $2,654, a state where arbitration panels have been in existence for many years.

John Sargeant

Executive Director

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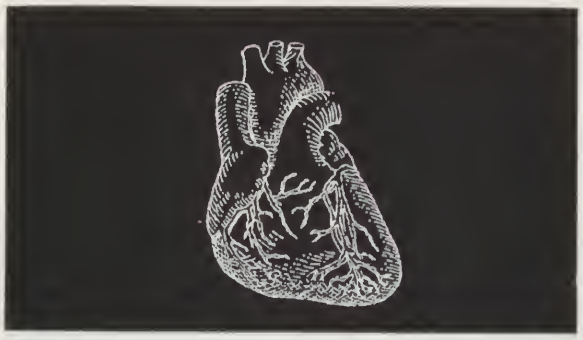
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MORRIS N. KOTLER, MD, Editor

*A Service of the Heart Association of Maryland*

**the heart page**

# Treatment of Cardiogenic Shock I

**LAWRENCE S. COHEN, MD**
**Professor of Medicine**
**Chief of Cardiology**
**Yale University School of Medicine**
**New Haven, Conn 06510**

*Information and reprint requests to Dr. Cohen.*

Although the treatment of cardiac arrhythmias following a myocardial infarction has decreased in-hospital mortality, cardiogenic shock remains a major cause of death. The mortality rate of cardiogenic shock is still in the range of 75% to 80%. It is estimated that over 100,000 individuals die yearly in the United States with this syndrome.

The clinical profile of the patient with cardiogenic shock is familiar. At some point after sustaining a heart attack the blood pressure starts to fall and is usually no greater than 80 mm Hg systolic. A tachycardia of 120-140 beats per minute is quite usual. The skin color is a dusky cyanotic gray and the patient is markedly diaphoretic. Urine output falls and the patient's sensorium becomes clouded. He will often be barely arousable or may be quite irrational. Terminally, ventricular tachyarrhythmias or heart block may occur.

If any one form of therapy had proved to be successful there would be little controversy concerning the proper medical therapy for this condition. Since the mortality is so high there have been many forms of therapy advocated. Since there is no uniform agreement concerning therapy the following approach is one which the author accepts as a generally reasonable one. It is axiomatic that therapy must be individualized for each patient and that no patient should receive a predetermined regimen.

The principles of therapy for cardiogenic shock follow from the pathophysiology of this condition. There is increasing evidence that the major factor leading to cardiogenic shock is an inability of the left ventricle to perform adequately as an effective pump. In almost all cases cardiac output is markedly diminished. Similarly, the hypotension which is a hallmark of this syndrome is in large part a consequence of low cardiac output. Since a critical pressure is necessary to maintain coronary filling, the hypotension has deleterious effects upon coronary filling and this in turn leads to further deterioration in the ability of the heart to support the circulation.

The two goals of therapy for this condition are: 1) to increase the cardiac output and 2) to raise systemic blood pressure. Both of these goals could be achieved if the left ventricle were helped sufficiently to augment its contractility.

## General Considerations

Since cardiogenic shock has such a dreadful prognosis, any patient with this syndrome should be treated in a specialized facility capable of handling the intricate problems that arise. Adequate bedside and central nursing station electrocardiographic monitoring should be available. An intravenous line capable of measuring central venous pressure should be present and fluids and medication may be administered through it. Although it is desirable under certain circumstances to be able to directly record arterial pressure through the use of a strain gauge and pressure transducer this latter intervention is not absolutely essential.

The measurement of central venous pressure may be important in unmasking hypovolemia as a contributory factor to the shock. With the widespread use of diuretics in cardiac patients it is not unusual for the patient who sustains a myocardial

infarction to have the problems of hypovolemia added to those of pump failure. Although it is well recognized that the central venous pressure may be totally normal, even if the patient is in pulmonary edema, knowledge of the central venous pressure does help management.

If the central venous pressure is low or normal and if the patient is not in gross left-sided congestive heart failure with rales, dyspnea, and roentgenographic evidence of pulmonary edema, judicious fluid therapy may be extremely valuable in reversing the state of circulatory failure. By taking advantage of the fact that as left ventricular end diastolic pressure and volume increase, so will left ventricular work and stroke output, a trial of 250 ml of isotonic saline or low molecular weight dextran may be tried. If this improves the circulatory state then another 250 ml may be given. At times a simple therapeutic maneuver such as fluid administration may be of great help in relieving many of the manifestations of this syndrome.

If central venous pressure is elevated in the absence of cor pulmonale, there is generally little chance that fluid administration will be helpful and the danger of causing pulmonary edema increases.

Other general principles such as oxygen administration and adequate pain relief will not be commented upon in this review other than to mention them. Pain, such as that which may occur with a myocardial infarction, may often lead to vagal reflexes which potentiate hypotension. Sufficient analgesia should be given to alleviate pain completely.

### Digitalis Glycosides

There is considerable controversy concerning the role of digitalis glycosides in the syndrome of cardiogenic shock. The argument usually cited by physicians who are reluctant to utilize digitalis is the recognized potential of digitalis to cause ventricular arrhythmias. More recently, it has been shown that any intervention which increases the velocity of myocardial contraction also increases myocardial oxygen consumption. One of the actions of digitalis is to raise the velocity of contraction and therefore it may raise myocardial oxygen consumption. It has been demonstrated that areas of myocardium which are marginally oxygenated following an occlusion of a coronary artery may become necrotic instead of ischemic if myocardial oxygen consumption is augmented.

However, if one accepts the thesis that the primary abnormality in cardiogenic shock is a marked depression of left ventricular contractility, then digitalis therapy becomes a very rational means of trying to restore circulatory integrity. Unfortunately a controlled study of digitalis therapy in cardiogenic shock is still not available.

It is the author's practice to administer digitalis early in the course of cardiogenic shock if the patient is not already taking this medication. The onset of action and peak effect of intravenous digoxin are such as to make it a perfectly reasonable drug to use. Between 1.0 and 1.5 mg digoxin is given intravenously in approximately a two-hour period in doses of 0.25 mg every 15 or 20 minutes.

It should be noted that pulmonary venous congestion or other signs of left heart failure need not be present in a patient with cardiogenic shock. The author feels, nonetheless, that digitalis plays a role in the therapy of the patient in cardiogenic shock. It should be recognized, however, that this form of therapy is not agreed upon uniformly.

### Vasopressors

The most easily recognizable feature of cardiogenic shock is hypotension. A variety of agents are available to raise arterial blood pressure. The sympathomimetic amines have received considerable use. These drugs have been classified into alpha or beta stimulatory agents. Alpha adrenergic drugs act primarily on the peripheral arterioles and raise blood pressure by increasing peripheral resistance. Included in this group are methoxamine (Vasoxyl) and phenylephrine (Neo-synephrine).

A second category of drug not only stimulates alpha adrenergic receptors in the peripheral arterioles but also stimulates beta adrenergic receptors in the myocardium. Metaraminol (Aramine), nor-epinephrine (Levophed), and epinephrine are examples of this type of agent. An example of a sympathomimetic amine which has only beta stimulating effects is isoproterenol (Isuprel). Since isoproterenol acts as a peripheral vasodilator it does not appropriately fall into the category of a vasopressor, although it is a sympathomimetic amine.

Although raising the blood pressure is generally considered an appropriate goal in the treatment of a patient in cardiogenic shock, the issue is not quite that simple. Since most filling of the coronary arteries occurs in diastole, the coronary arteries do require a certain level of pressure in the central aorta in order to fill. Myocardial function is dependent upon adequate coronary bloodflow and will deteriorate in the presence of inadequate perfusion pressure.

It has been shown, however, that drugs which act only on peripheral arterioles, thereby raising blood pressure by elevating peripheral vascular resistance, may have a deleterious effect upon patients in cardiogenic shock. If left ventricular function is sufficiently impaired to place a patient into cardiogenic shock, increasing the resistance against which the left ventricle must pump may further decrease cardiac output.

For this reason, drugs which act solely on the peripheral vasculature such as methoxamine or phenylephrine have little or no role in the therapy of cardiogenic shock.

Agents which act both on the beta receptors of the myocardium and the alpha receptors of the periphery have been used most extensively. It is wise to use as little of these agents as are necessary to maintain an adequate perfusion pressure and it is also advisable to give these agents by intravenous drip rather than intramuscularly. By so doing, blood pressure can be titrated more precisely. It is not necessary for the blood pressure to be brought to normal levels. A systolic blood pressure of 90-100 mm Hg is usually adequate. It is the author's practice to place 50 mg of metaraminol in 500 ml of 5% dextrose in water. This is infused at a rate sufficient to elevate blood pressure the desired amount.

Nor-epinephrine (Levophed) is another sympathomimetic amine which has potent effects upon both the periphery and the central circulation. Although blood pressure can generally be raised by an intravenous drip of nor-epinephrine, experience indicates that relatively few patients survive if it becomes necessary to use this drug in order to sustain blood pressure.

## Glucagon

Glucagon, a hormone which has been shown to raise blood sugar has also been utilized recently in patients with cardiogenic shock. Although its mechanism of action is not known precisely, it does have the property of increasing cardiac contractility, possibly by augmenting the synthesis of cyclic AMP.

Initial studies of this agent in the animal laboratory and in the human cardiac catheterization laboratory led to some enthusiasm for its use in patients with myocardial infarction and shock. Other than for some anecdotal reports of its efficacy this agent has generally been disappointing in the treatment of this condition and has generally been abandoned as a useful therapeutic agent.



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*John Galsworthy*

FREDERICK J. BALSAM, MD, Editor

**rehabilitation medicine**

# An Approach to Aphasia for the Physician

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When talking with an aphasic patient, what can the physician expect? Perhaps if one were to understand an aphasic's perception of this encounter, one could better cope with the situation. The patient might see words mouthed by the physician, yet these words sound like jargon to him, or perhaps he comprehends only some of the words uttered at the beginning or end of questions. The physician begins to speak louder and now the patient really has difficulty separating words from their undue overall emphasis. He sees the doctor take pen in hand and begin to write questions out for him to answer, but unfortunately the letters seem to have no meaning, especially when grouped to form words. He may see these forms as blurred or, because of homonymous hemianopsia (which he cannot label or describe), he might be prevented from perceiving the whole word.

When he tries to respond verbally to questions, he finds that he has little or no control over how his mouth forms sounds or, even worse, that the words that come forth are unexpected, while those he desires to use he cannot recall. So he tries to write down his message and encounters confusion in how to hold his pen, how to form and construct letters, how to spell words, or how to use his grammar school knowledge to formulate sentences. What follows are frustration and confusion for the patient and the physician, and multiple explanations of the same information.

Since there are undeniable frustrations and confusions for patient and physician, it will be helpful in working with aphasics to treat the following topics: 1) specific language deficits, 2) behavior characteristics in patients having language problems, 3) ways to help aphasic patients find words to express themselves (triggering techniques), 4) basic predictors for improvement in patients with language problems, and 5) role of the speech clinician and the need for early referral for speech therapy.

## Language Deficits

The possible residual language deficits with which a stroke patient might be faced are represented here as SRWL deficits. This mnemonic tetrad, SRWL, Speaking, Reading, Writing and Listening, is most useful for those truly interested in helping the aphasic patient. To say a person is aphasic is to use a broad label, as deficits range from mild to severe and any one individual might have involvement in as few as one or two modalities or as many as three or four. Each individual truly has individual limitations. An additional and most important preface is necessary: the more easily recognizable difficulties are to be found in speaking and writing; the more difficult to detect are in the patient's ability to listen and read, since we cannot readily detect how much of what is read or heard is recognized and then how much is understood and retained.

The following illustrations give some idea of the kinds of errors an aphasic might make. The error categories span all four modalities, although examples will be demonstrated in the areas of speaking and writing performance. He may misplace a sound or syllable.

For example, instead of saying, "Stay tuned for the news," he may say, "Stay stewed for the nudes." In writing, he may abbreviate the word *Boulevard* as *Bldv.* instead of *Blvd.* He may recall only the beginning of a word correctly; he may say *refrigadaire* instead of *refrigerator;* he may write *wach* instead of *watch.* He may substitute

a word which sounds the same as the one he is trying to recall, "I need a little *kime* to *organate* myself"; or he may write, "You are great to *thing* of me." He may have the general concept but be unable to recall the specific word and make a semantic substitution, using a word closely related in meaning or category; he may say *old daddy* instead of *grandfather;* he may write *boy* for *girl, chair* for *table, apple* for *orange.*

He may communicate in a telegraphic manner, referring to the *Book of Genesis* as *Man and Lady,* writing *roof leak* instead of the complete sentence, *The roof is leaking.*

He may have the idea but be unable to organize the grammar and use a word in a sentence as a key word or give its definition. For example, when asked, "What is speech?", the patient might reply, "Well, . . . speech is a noise word." When asked to read the number *14,* he may say, "It is a *4* with a *1* in front of it." When asked to write a word, he may be able to tell how many letters it has and perhaps what letter it starts with, but is at a loss to give the complete correct responses; but these automatisms cannot be used out of context. For example, when asked to say the word *NO,* he may say, "No, I can't." He may be able to write the series of numbers from *1* to *10,* but cannot write the number *3* to dictation and out of sequence.

## Behavior Characteristics

Patients with language problems such as those just presented exhibit certain behavior characteristics. These characteristics should be noted for their presence or absence since they must be utilized, adapted, or modified for successful therapy. The following types of behavior form another difficulty which the stroke patient with language problems must endure and of which the physician must be aware.

In dealing with a patient who has a language problem, presence or absence of the following behaviors should be noted: 1) lethargy, 2) perseveration, 3) mental confusion, 4) adaptation to and compensation for disability and emotional acceptance of present limitations, 5) active or passive participation in a communication or learning situation, 6) monitoring ability or awareness of one's own errors, 7) ability to self-correct errors, 8) ability to imitate the examiner in performance and/or verbal tasks, 9) ability to work alone or the need for constant encouragement, 10) consistency of responses, 11) latency in responding, 12) compensatory use of various types of nonverbal communication, 13) emotional lability, 14) catastrophic responses, 15) tolerance for frustration, 16) attention span, and 17) short versus long-term memory span.

## Help for the Aphasic

Now, if aphasic stroke patient exhibits such complications of language and behavior, questions of proper approach arise. Any method or combination of methods that assist the patient are best for that patient. In the adult without stroke, four channels are open for expressing himself: speech, writing, gesture usage, and facial expression. In the stroke patient with expressive disturbance, often the only channels left open are gestures combined with facial expression. Receptively, the adult without stroke takes information from his environment by reading, listening, and watching facial and meaningful movements of people around him. In the stroke patient with receptive disturbance, circumstantial clues may have to be gathered by simply watching facial and body movements of those trying to communicate with him.

It is important to remember that limitation in expressive skills does not necessarily imply significant damage of receptive skills. Recalling the mnemonic tetrad, SRWL, if a patient is not speaking, perhaps he can still read, write, and listen well. Therefore, one might try encouraging this patient to write to express himself. If a patient seems not to be comprehending words spoken to him and has no peripheral loss in hearing acuity, it might be profitable to write the message for him, using simple sentence construction, and have him try to read it. Questions should be put to the patient after the physician has secured his attention, and the questions should be phrased so that they are short, concise, and devoid of the natural tendency to incorporate redundancies. The patient should be spoken to in a normal tone of voice, as the problem lies in the area of comprehension, not auditory reception.

If the person is in the habit of wearing corrective appliances (eyeglasses, a hearing aid, or dentures), these should continue to be worn routinely. Standing or sitting on the patient's unaffected side has immeasurable benefits. The patient should be encouraged to try to express himself as best he can with the listener trying to glean the general context.

Triggering techniques are only partially beneficial, once the general idea is established. These would include asking the patient to try to put the key word at the end of an incomplete sentence, giving a list of words that rhyme with the lost key word, giving words opposite in meaning to the desired word, using a synonym permitting generalities and circumlocution, and describing a category this word falls in. The patient should

also be encouraged to try to write key words, or at least draw a picture of what he wishes to express; he may point to objects in the room or cards in his wallet or use gestures or pantomime to communicate.

### Predictors for Improvement

We have briefly touched on language deficits, behavioral characteristics of the aphasic, and the what-to-do for him. At this point a natural question may arise, "Just what are the predictors for the aphasic?" Some contend that if speech is to return at all, it will return by itself. "Just what are the predictors?" seems a simple question for which there is no simple answer. Five predictors are suggested: 1) monitoring ability, 2) self-correction ability, 3) minimal emotional lability, 4) ability to imitate performance and/or verbal model set by examiner, and 5) stickability as opposed to teachability. This last predictor is based on the patient's ability to be taught new material *and* retain the material taught.

### Speech Clinician's Role

The contention that if speech is to return it will return by itself is only partly correct, and it is only partly true, because recovery *is faster* through planned language stimulation. The patient is motivated to work harder in therapeutic activities, at this time, because he sees progress. Secondly, the speech clinician can and does create a positive effect through interest shown to the patient, by actual time scheduled for this purpose, and by spurring the family to take a more active part in treatment.

We have suggested appropriate roles for the speech clinician: to diagnose, to capitalize on positive behavior characteristics, to make adaptations for undesirable characteristics, to assist the aphasic in discovering ways to communicate, to stimulate and encourage the patient. There are additional features of the clinician's role that extend beyond the patient, as beneficial as direct patient contact. These involve explaining language deficits to family members and later to prospective employers. And lastly, a clinician occasionally has the opportunity to present his views to physicians so that speech and hearing rehabilitation referrals may be made early for maximum recovery.

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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland



# ALCOHOL-RELATED ILLNESSES—PART II

HEAVY DRINKING, ALCOHOL ABUSE, AND ALCOHOLISM have been implicated as primary or related causal factors in a large number of pathological conditions, although the exact frequency of most of these conditions is not known. For example, alcoholism is often associated with nutritional disorders, especially of vitamins such as folate, niacin, and thiamin. Deficiencies of these vitamins may be responsible for diseases of the neurological, digestive, and other body systems. Diseases of the heart and muscles, of the blood and other tissues, as well as mental disorders, are common in the course of prolonged alcohol abuse and alcoholism. Moreover, alcoholic persons whose alcohol dependency is not successfully treated are subject to an exceptionally high rate of morbidity and mortality. They more frequently fall victims to all sorts of illness not directly connected with alcoholism, and their lifespan is reduced by as much as ten to 12 years.

## Alcohol and the Heart

The occurrence of heart disease in connection with heavy drinking was described nearly 100 years ago. Later reports of the frequent occurrence of beriberi heart disease in alcoholic patients suggested to many that in this condition alcohol itself might not be the injurious factor. Rather, a nutritional defect, especially deficiency of thiamin (vitamin $B_1$), was postulated. In recent years a distinction between nutritional heart disease and alcoholic cardiomyopathy has been reported with persistence of the latter after administration of thiamin. Alcoholic cardiomyopathy occurs usually in men with a long history of alcohol abuse. The clinical characteristics include either slow or sudden onset of left- and right-sided congestive heart failure. A large heart, distended neck veins, narrow pulse pressure, elevated diastolic blood pressure, and peripheral edema are characteristic. Severe liver disease or neurological manifestations of vitamin deficiencies are not usually seen in these patients.

The experimental administration of intoxicating amounts of alcohol to men results in increases in the resting cardiac output, heart rate, and myocardial oxygen consumption, without a change in the stroke volume. The increase in oxygen consumption after acute intoxication suggests a decrease in the mechanical efficiency of the heart. This action of alcohol has also been produced in experimental animals. In men, experimental blood alcohol levels lower than 0.65% increased the effective coronary blood flow. However when the alcohol was 0.19%, a marked diminution of the velocity of the left ventricular contraction was observed. In alcoholic persons, catheterization of the coronary sinus blood showed a consistently altered balance of oxidative overt enzymes, suggesting that enzymes within the mitochondria are affected in these patients, even when they do not have manifest heart disease. These effects were obtained in experiments with intoxicating amounts of alcohol.

Although the appearance of the heart in alcoholic cardiomyopathy is characteristic, neither the gross nor the microscopic findings are specific. Usually the coronary arteries are free of signif-

*Reprinted with permission from "First Special Report to the US Congress on Alcohol and Health From the Secretary of Health Education and Welfare," December 1971, DHEW Publication No. (HSM) 72-9099.*

*This is the second in a series of three articles originally published in Chapter Four Alcohol and Health, and authoritative and up-to-date examination of the social and medical dimensions of alcoholism. You may purchase this booklet from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402 — Price $1.50, Stock No. 1724-0193.*

icant arteriosclerosis or other occlusive changes, and the valves are entirely normal. In most cases the heart is large and flabby, with focal myocardial fibrosis and endocardial thickening. In some instances, only cardiac enlargement is seen. Under the microscope the heart muscle cells may reveal loss of striations, pyknotic nuclei, vacuolization, and hydropic change. From studies using the higher resolving power of the electron microscope, ultrastructural changes remarkably similar to those seen in the alcohol-damaged liver have been reported.

The clinical, biochemical, pathological, and ultrastructural data all provide evidence that alcoholic cardiomyopathy is indeed a distinct entity. This concept is supported by the report that administration of alcohol to a patient receiving a good, vitamin-supplemented diet for five and one half months produced the clinical syndrome of alcoholic cardiomyopathy, which improved after alcohol was discontinued. The administration of alcohol with an adequate diet to rats led to the consistent accumulation of fat in the heart, and similar treatment over a period of months produced a decrease in cardiac function. Under electron-microscopic examination, the same sort of studies in mice demonstrated changes in the heart similar to those observed in human alcohol cardiomyopathy.

The mechanism and pathogenesis of alcoholic heart disease are unknown at this time. Whether a direct effect of ethanol on heart cells plays a role, or whether a metabolic product such as acetaldehyde does, remains to be seen. Patients with alcoholic cardiomyopathy are treated conservatively with the usual measures for congestive heart failure. As in the case of liver cirrhosis, absolute abstinence from alcohol is a prerequisite for successful treatment. Mural thrombi on the diseased endocardium represent an occasional complication, which may lead to strokes. Prolonged bed rest which "unloads" the heart appears to be highly beneficial. Most patients who are treated with bed rest and adjunct therapy will recover if they abstain from alcohol. A small number of patients, however, have irreversible heart disease by the time they are seen by a physician.

## Alcohol and the Gastrointestinal Tract

The effects of alcohol on other parts of the gastrointestinal tract have not been as intensively studied as those on the liver, but sufficient knowledge is available to indicate that chronic heavy drinking has a variety of injurious effects on the gastrointestinal system. The association of diarrhea with alcohol intoxication was noted by Hippocrates, who prescribed wine as a purgative.

Although most of the harm associated with heavy drinking occurs after its absorption, when strong alcoholic beverages are taken the irritating effect may cause direct local injury. The possible sites of such injury are the mouth, stomach, and esophagus. An increased frequency of cancer of these parts of the digestive tract has indeed been reported among alcoholic persons. The possible relationship to the irritative effect of alcohol is complicated, however, by the fact that alcoholic persons are usually also heavy smokers.

### Stomach

Ingestion of alcoholic beverages stimulates acid production in the stomach, presumably by enhancing the secretion of the hormone gastrin. In addition, emptying of the stomach is delayed, and from animal experiments it appears that strong alcohol solutions may damage the gastric mucosal barrier. In that event, back diffusion of acid would occur, damaging the lining of the stomach. The combination of salicylate and alcohol or alcohol alone, has been shown to cause a movement of hydrogen ions out of the stomach, and the passage of sodium and potassium ions into it. Since alcohol leads to alteration in the electrical properties of the stomach wall, a direct injury by the alcohol has been suggested.

Gastritis and achlorhydria are common chronic conditions in alcoholic persons, and gastric ulcers have been reported frequently. One of the life-threatening emergencies in medical practice is massive upper gastrointestinal hemorrhage. More than half of the patients with hemorrhagic erosive gastritis had ingested alcohol or aspirin or both shortly before the onset of bleeding. Both superficial and atrophic gastritis were more frequent in the alcoholic patients than in a control population examined by Dinoso and associates. However, whether either the superficial or the atrophic gastritis are direct sequels of alcoholic beverages has not been settled.

### Small Intestine

Maladies of the small intestine are not often a medical complication in alcoholism, but occasionally they are troublesome. Malabsorption of various substances such as thiamin, folic acid, xylose, fat, vitamin $B_{12}$, have been reported in alcoholic patients. The administration of large doses of alcohol experimentally has been reported to interfere with intestinal transport of amino acids both in test-tube experiments and in studies of animals and man. Prolonged heavy intake of alcohol by human volunteers, together with excellent protein and vitamin intake, re-

sulted in depression of vitamin $B_{12}$ absorption from the ileum, the distal part of the small intestine. This suggests that alcohol can impair the function of the ileum even when nutrition is adequate. Since alcohol is generally absorbed before reaching the ileum, its interference with vitamin $B_{12}$ absorption seems to be dependent upon an indirect effect. Specimens of intestinal tissue from alcoholic patients have not usually appeared abnormal when examined by light-microscopy. However, administration of alcohol to volunteers for three to four weeks resulted in changes of the small intestine, revealed by electron-microscopic examination. All the intestinal injuries associated with chronic alcohol abuse appear to be rapidly reversible. The mechanism by which alcohol affects small-intestine ultrastructure, absorption, and transport is at present unknown.

### Pancreas

Alcoholism is occasionally associated with pancreatitis and pancreatic insufficiency. Individuals with a long history of alcohol abuse show a diminished response to pancreatic stimulation in volume, bicarbonate concentration, and amylase secretion. Moreover, a provocation test in alcoholic patients leads to increased amylase and lipase activity in the serum, indicating subclinical pancreatic damage. These abnormalities appear to be reversible when alcohol is discontinued. It is not feasible to perform pancreatic biopsy in volunteers, but studies in rats given heavy alcohol doses over long periods have disclosed ultrastructural changes reminiscent of those seen in the liver. A decrease in pancreatic lipase may secondarily lead to malabsorption of fat in the small intestine.

The occurrence of pancreatitis may be related to a direct effect of alcohol or to spasm of the sphincter of Oddi, which would increase pressure in the pancreatic duct. Since alcohol increases gastric acidity, a greater elaboration of secretin may follow, which would result in increased secretion against an obstructed duct. This situation is known to favor the development of pancreatitis. In addition, the metabolism of pancreatic cells may be disturbed, as evidenced by the report of decreased protein synthesis animals after prolonged treatment with alcohol.

### Alcohol and Muscle

Although muscle weakness in alcoholic persons has been known for almost 150 years, a well-defined syndrome of muscle disease associated with chronic alcohol abuse was described in Russia in 1928 and reconfirmed there in 1962. In the United States this syndrome was first recognized in 1957 and since then has been increasingly accepted as a complication of alcoholism. The disorder has been classified into three general forms: a) subclinical myopathy; b) acute alcoholic myopathy; and c) chronic alcoholic myopathy.

The subclinical variety combines a lack of symptoms with alterations in the levels of certain enzymes in the blood serum, of which creatine phosphokinase (CPK) is the most important.. A majority of patients admitted to the hospital following prolonged consumption of large amounts of alcohol show increased serum CPK, but in the largest reported series about 40% had a normal serum CPK. In addition, a majority of the alcoholic patients exhibit a diminished rise of lactic acid in the blood as a response to ischemic exercise.

Acute alcoholic myopathy may present itself in several different forms. In some patients, the only symptom is sudden muscle cramps which occur from a few minutes to a few hours apart, but usually last for only about a day. Although the cramps are most common in muscles of the extremities, isolated contraction of various muscles, particularly of the abdominal wall, have been reported. Perhaps the most dramatic form of acute alcoholic myopathy—certainly one of the most striking complications of alcoholism—is associated with a severe myoglobinuria, ie, the occurrence of muscle pigment in the urine.

An alcoholic debauch is followed by severe pain and swelling of involved muscles, together with a pronounced weakness. Arms and legs may both be involved, the latter more frequently. This form of alcoholic myopathy is generally seen in patients with long histories of alcoholism, and consequently may be associated with severe liver disease. Recovery is the rule if alcohol is discontinued, although acute renal failure may be precipitated by myoglobinuria. In recovered individuals, pain and swelling of muscles generally disappear after several days or weeks but the basic process may progress inexorably to chronic myopathy, without further symptoms of the acute phase. Laboratory examination of patients with acute alcoholic myopathy generally discloses increased serum CPK and a diminished rise in blood lactic acid after ischemic exercise.

Persons with a history of prolonged severe alcoholism may develop chronic alcoholic myopathy insidiously or after one or more episodes of clinically recognizable acute myopathy. The principal findings then are weakness and atrophy, which may affect almost any muscle in the body but are most common in the legs. Proximal mus-

cles are generally involved to a greater extent than distal ones. Episodes of acute myopathy may also occur in patients who are suffering from the chronic form. Since chronic alcoholic myopathy is usually found after a long history of alcoholism, it is important, on medical examination, to distinguish the muscle disease from peripheral neuropathy or encephalopathy associated with nutritional disturbances or acute effects of alcohol on the central nervous system.

Acute and chronic alcoholic myopathy are associated with pathological changes observable by both light-microscopic and electron-microscopic examination of muscle tissue. Focal atrophy of individual muscle cells has been seen in the subclinical form of the disease. Severe acute myopathy, usually with myoglobinuria, results in necrosis, edema, and fragmentation of muscle fibers.

The pathogenesis of alcoholic myopathy has not yet been elucidated. Both ischemia and nutritional deficiency have been suggested as possible causes. An etiology other than a direct effect of alcohol was supported by a lack of increase in CPK after infusion of alcohol into dogs, and a similar response when normal human subjects were tested after social drinking. However, administration of alcohol to rats for nine months showed decreased substrates of the citric acid cycle in muscle, when compared with pair-fed controls. A recent experiment in human volunteers suggests a direct toxicity of alcohol. In three volunteers, intake of alcohol sufficient to provide 42% of the total calories for four weeks led to increased serum CPK and striking ultrastructural changes in muscle, similar to those observed in patients with acute alcoholic myopathy. In these studies, the volunteers received adequate amounts of all dietary constituents, including vitamins, folic acid, and minerals.

In summary, chronic heavy alcohol ingestion is associated with an acute and chronic disease of muscle which may be independent of nutritional factors, but in some clinical cases the condition has been connected with water and electrolyte imbalance.

#### References

A complete listing of the references used with this article may be secured from Mr. Ludwig L. Lankford, Division of Alcoholism Control, 2305 N Charles St, Baltimore, Md 21218, or from *Alcohol and Health*. Information and reprint requests should also be directed to Mr. Lankford.




**MARY ADELAIDE NUTTING, Pioneer of Modern Nursing, by Helen E. Marshall, The Johns Hopkins University Press, Baltimore and London, 1972.**

One of the principal architects of the modern profession of nursing, Mary Adelaide Nutting, was also an innovative educator and an advocate of better working conditions for nursing. Professor Marshall traces Miss Nutting's career from student nurse to successful administrator and dynamic teacher.

On her graduation from nurses' training in 1891, Miss Nutting became Sir William Osler's head nurse and four years later she became principal of the school. One of the founders of the American Journal of Nursing, she was a firm believer in the importance of professional societies and journals.

This is a book well worth reading by students of history of nursing and medicine and it is revealing in that it provides insight into many things taken for granted today.

**GENERAL UROLOGY, by Donald R. Smith, MD, Lange Medical Publications, Los Altos, Calif, 1972.**

This book, originally written for the medical student and the medical practitioner who has not specialized in urology, now adds urologic residents to those for whom its contents will have an appeal.

The general thesis of the book is that although many urologic disorders produce few or no symptoms, clues to their presence are in careful history-taking and physical examination and, above all, a personally performed study of the fresh-stained urinary sediment and utilization of the PSP renal function test, which also permits estimation of the amount of residual urine. New material has been added and emphases changed throughout this new edition.



**PAUL F. GUERIN, MD, Chairman**
**Library and History Committee**
**ELIZABETH SANFORD**
**Librarian**

**library**

# 71st MEDICAL LIBRARY ASSOCIATION CONFERENCE, 1972

A more delightful setting could not have been selected for the 71st annual meeting of the Medical Library Association than the Hotel Del Coronado, Coronado, Calif, across the bridge from San Diego.

The meeting was held June 11-15, 1972, so in order to get settled and be able to see something of San Diego we went on Saturday. To our surprise people with reservations at this historic hotel were already being directed to other nearby motels. But, apparently due to our early reservation, we were given a beautiful lanai room on the first floor facing the ocean. Needless to say, we held open house for our fifth floor friends and those who had been placed elsewhere. Our back door opened on the beautiful courtyard garden full of oleanders, lily of the Nile, banana trees, palms, and other tropical plants. It was a pleasure to be privileged to spend convention time in surroundings steeped in memories of a past grand era. But enough of this; the reason for the trip was to renew contacts with other librarians engaged in similar activities, to learn from the experts developments in library procedures, new sources of information, and the latest legal measures which have transpired relative to the dissemination of scientific information.

Mrs. Bernice M. Hetzner opened the conference followed by welcomes from Clifford Grobstein; PhD, vice chancellor—Health Sciences, and dean, Medical School, University of California, San Diego, and others from the San Diego area. The keynote address, given by Robert D. Tschirgi, MD, PhD, professor of neurosciences, University of California, San Diego, was entitled: **Should scientists communicate? And with whom?** Dr. Tschirgi was a lively, convincing speaker who vividly urged that scientists realize the importance of communicating with librarians, information specialists, and other professional media to utilize the greatest possible resources.

The following general session, with Donald Washburn, DDS, and immediate past president of MLA, presiding, included a discussion of: **MEDLINE—Actualities and plans,** by Davis B. McCarn, NLM; **CAN/SDI — Experience with multiple source computer based current awareness services in the National Science Library, Canada,** by Inez Gaffney, NRC, Canada; and **Information, transmission and the brain** (a demonstration using two young women as subjects), by Reginald G. Bickford, MB, BChir, professor of neurosciences, University of California, San Diego.

After this, the Janet Doe Lecture was given by Scott Adams, now with the National Academy of Sciences, Washington, DC. He traced the history of the National Library of Medicine and the medical library progress under the title **Way of the innovator.**

The Tuesday business meeting was followed by group dinners. Wondering why a pediatrician was speaking to the History of Medicine Group, I attended that dinner and was highly pleased and inspired by the talk, **A bibliophile looks at pediatrics,** by Frederick A. Frye, MD, assistant clinical professor of pediatrics, University of California, San Diego. His enthusiasm was contagious, his talk illustrated with slides and the actual rare volumes he brought from his personal library.

A new group was being formed this year which met Tuesday evening very late to discuss **Professionals, professional organizations and social issues.** This was an organization meeting, so it remains to be seen whether it develops into a bona fide MLA group.

Since it would be too time consuming to report

on all the meetings, mention of some subjects discussed at the concurrent meetings will have to suffice. The toxicology session took up TOXICON, the new information service of NLM on toxicology. Goals of the NLM program encompassed both a review of resource grant applications and the intramural training programs. Multimedia, new reference services and techniques, and management challenges and solutions were other broad subjects for panel type discussions.

After the Thursday afternoon business meeting and inaugural address by the new president, Miss Helen Crawford, everybody relaxed at the banquet which ended with entertainment, Latin American style, including some beautiful folklore dancing.

The only complaints about the accommodations and planning would be that the Beach Party really was a great disappointment since nearly everyone expected a picnic-type supper, probably with drinks of some kind, and what was served consisted of 10% of the amount ordered—of the hors d'oeuvre variety. If you didn't care for beer (furnished by one of the publishers) you had to purchase a soft drink at the pool stand. This for $6.00 was a bit too much and we understand MLA asked for a refund from the hotel. Maybe this will go into a scholarship fund.

The Medical Society Group Luncheon has not been mentioned since there was no program presented, merely a gathering of 22 society librarians. My personal feeling is that if our organizations are paying $6.25 for a luncheon we should have the privilege of hearing a well-planned short program. Surely this is not an impossibility!

As usual, there was little time for the exhibits. Maybe sometime the exhibitors will be allowed to set up Monday when many people would have free time to browse leisurely.

## History and Rare Books News

Recently we checked the listing, **Early American Medical Imprints,** first edition, by Robert Austin and found that this library holds 395 titles of the 2,106 entries. This is approximately 20% of the titles included and exceeds that of many libraries of comparable size. The History and Rare Books collection of this library totals about 10,000 volumes which may be used for research and study in the library. A list of our holdings by number has been sent to the National Library of Medicine History of Medicine Division which might be consulted by inquiring there. As yet, these holdings have not been added to the Austin list, however.

## NEW ACCESSIONS – BOOKS (Arranged by Subjects)

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*- George Sarton, from "The History of Medicine Versus the History of Art"*

# Would it be useful in clinical practice to have government predetermine drugs of choice?

# Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

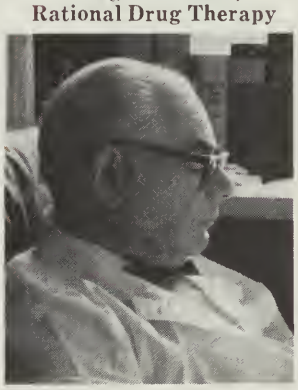
86.7%
No, it would not be useful.

# Dialogue

# Would it be useful in clinical practice to have government predetermine drugs of choice?

## Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really be determined.

The Bureau of Drugs has suggested the package insert as a possible means of communicating information on relative efficacy of drugs to the physician. I find this objectionable, since I do not believe the physician should have to rely on this source for final scientific truth. There is also a practical objection: Since few physicians actually dispense drugs, they seldom see the package insert. In any event, I would maintain that the physician should know what drug he wants and why without depending on the government or the manufacturer to tell him.

Undoubtedly, physicians are swamped by excessive numbers of drugs in some therapeutic categories. And I am well aware that many drugs within such categories could be eliminated without any loss, or perhaps even some profit, to the practice of medicine. But, in my opinion, neither the FDA nor any other single group has the expertise and the wisdom necessary to determine the or "drug of choice" in a areas of medical practice.

# Maker of Medicine

enneth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
Eli Lilly and Company



In my opinion, it is not
e function of any governent or private regulatory
ency to designate a "drug
choice." This determinaon should be made by the
ysician after he has reived full information on
e properties of a drug,
d then it will be based on
s experience with this
ug and his knowledge of
e individual patient who
seeking treatment.

If an evaluation of comrative efficacy were to be
ade, particularly by govnment, at the time a new
ug is being approved for
rketing, it would be a
eat disservice to medine and thus to the patient
he consumer. For exame, when a new therapeuagent is introduced, on
e basis of limited knowge, it may be considered
be more potent, more
fective, or safer than
oducts already on the
rket. Conceivably, at
is time the new drug
uld be labeled "the drug
choice." But as addinal clinical experience is
cumulated, new evidence
ay become available.
ter, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin $B_{12}$ as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of "*drugs of choice*" is to be avoided.

## Opinion & Dialogue

**What is your opinion, doctor?**
**Send us your comments on the above issue.**

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# Yellow Fever Epidemics of the Late Eighteenth Century in Baltimore

DOUGLAS CARROLL, MD
Baltimore City Hospitals
Baltimore

*This is the sixth of an 11-part series of articles on the history of medicine in Maryland from 1634 to 1835 as written by Dr. Carroll.*

*"Then it came to pass that a pestilence fell on the city,*
*Presaged by wondrous signs, and mostly by flocks of wild pigeons*
*Darkening the sun in their flight, with naught in their craws but an acorn.*
*And, as the tides of the sea arise in the month of September.*
*Flooding some silver stream till it spreads to a lake in the meadow,*
*So death flooded life, and, o'erflowing its natural margin,*
*Spread to a brackish lake the silver stream of existence.*
*Wealth had no power to bribe, nor beauty to charm, the oppressor,*
*But all perished alike beneath the scourge of his anger;*
*Only, alas, the poor, who had neither friends nor attendants,*
*Crept away to die in the almshouse*, home of the homeless."*

*Evangeline—Henry Wadsworth Longfellow*

**Philadelphia Almshouse, probably 1793.*

It is difficult to get an accurate history of yellow fever in Baltimore for a number of reasons:

1) Yellow fever and malaria were hard to separate diagnostically. Some physicians believed yellow fever to be a severe form of intermittent fever (malaria), and therefore did not report yellow fever as a separate entity.

2) There was a reluctance among practicing physicians, health officers and municipal authorities to acknowledge the presence of yellow fever, since acknowledgment of an epidemic caused panic, an exodus from the city, possible quarantine of ships, and loss of travelers and business.

3) One of the criteria for diagnosis was the presence of an epidemic, so that if there were but a few cases of yellow fever, they were probably not recognized or not acknowledged.

4) The record kept was often inaccurate and contradictory.

Nearly all early observers report certain characteristics of the Baltimore epidemics:

1) They all began at Fell's Point, usually near the wharfs.

2) They began in the late summer and disappeared with the first frost.

3) Cases remained limited to Fell's Point unless there was a strong wind, which was assumed to carry a miasma from Fell's Point to the place where the new cases arose.

4) No secondary cases arose. Therefore, the disease was not contagious.

These four observations were all correct. One conclusion which seemed to follow was that since the disease was not contagious, it could not be imported, and therefore must be local in origin. Therefore, quarantine was unnecessary.

All these observations can be explained today by the knowledge that the mosquito vector for yellow fever (Aedes aegypti) is not a native mosquito, but was imported to Fell's Point on ships from the West Indies. The mosquitoes got their yellow fever virus from shipboard yellow fever victims and carried it ashore. Thus the few cases of yellow fever which developed among the inhabitants of Fell's Point did not spread very far because of a lack of the vector.

In 1793 Smith[1] notes that the mosquitoes are intolerable (10/4/1793), although they were nearly gone one week later (10/11/1793). Smith recounts that Dr. George Buchanan was much frightened of taking the disease after he had attended one of the victims of yellow fever who died. Smith himself, however, recognizes that no cases had arisen from contact with the two victims of yellow fever in Baltimore in 1793.

Drysdale in 1794 had also noted the prevalence of mosquitoes: "Locusts were not more numerous in the region of Pharaoh, than mosquitoes through the last few months; yet these insects

**Table 1: Summary of References to Yellow Fever Epidemics in Baltimore Between 1793 and 1819**

| | Deaths | References | Origin | Contagious | Phlebotomy | Mercury |
|---|---|---|---|---|---|---|
| 1793 | 2 | William Smith (1) | Imported from Phila. | No | | |
| | | Bd. of Health (2) | | | | |
| 1794 | 360<br>2 MDs | Thomas Drysdale (3) | Local | Yes | Yes | Calomel to salivation |
| | | John Coulter )<br>George Brown ) (4)<br>Lyde Goodwin ) | | | | |
| | | John Ross (5) | | | | |
| | | Gustavus Scott (6) | | | | |
| | | Anonymous (7) | | | | |
| | | Joseph Mackrill (8) | Imported | Yes | Yes | |
| | | Gentleman of the Faculty (9) | Local | No | | |
| | | Nathaniel Potter (10) | Local | No | | |
| 1797 | | John Coulter (11) | Putrid Vegetables | No | Yes | Yes |
| | | James Steuart (12) | | | Yes | Yes |
| | | Henry Stevenson (13) | | | No | Rare |
| | | John Coulter )<br>Joseph Allender )<br>J. Jaquitt )<br>Lyde Goodwin ) (14)<br>Daniel Moores )<br>John Davidge ) | Connected with launching of frigate<br>Local | No | | |
| | | John B. Davidge (15, 16, 17) | Local | No | Judicious Use | Calomel Ointment |
| | | Nathaniel Potter (10) | Local | No | | |
| 1799 | 4 | Nathaniel Potter (10) | Local (cellar) (Swamp) | No | | |
| 1800 | 1197 | Board of Health (18) | Local Swamps Filth | No | | |
| | | Pierre Chatard (19) | A bilious fever | | Yes, but used less with increasing experience | No |
| | | Daniel Moores (20) | Local | No | | |
| | | Henry Stevenson (21) | May be imported | No | No | No |
| | | John Crawford (22) | Doubts miasma theory | No | | |
| | | James Smith (23) | Local effluvia & filth | No | | |
| | | A. Mace (24) (25) | Local | | Yes | Yes |
| | | William Hayes, Jr. (26) | Local | | Yes | Yes |
| | | John Crawford (27) | A living principle | | | |
| 1819 | 2287<br>4 physicians | Pierre Chatard (30) | | | | |
| | | Edward Johnson (31) | Local | No | | |
| | | Official Statement (32) | Local | No | | |
| | | D. M. Reese (33) | Vegetable Putrifaction | No | Most important remedy | Infinite Importance |
| | | John Revere (34) | Local | No | | |

(Table: Continued)

| Comment |
|---|
| Letter from prominent layman notes that no one who has not been in Philadelphia has gotten Yellow Fever. Two have died in Baltimore, one in Almshouse. |
| Baltimore is free of Yellow Fever. |
| Peruvian Bark, a poison. Friend of Benjamin Rush. Good description, published posthumously. |
| 8/15/94 No Yellow Fever at Fell's Point at this time. |
| 8/15/94 Quarantine officer reports he is on the job and has seen no Yellow Fever. |
| 8/29/94 Committee on Health reports no Yellow Fever. |
| 8/29/94 Attacks Dr. George Brown for saying Yellow Fever is not contagious. |
| Peruvian Bark is "sheet anchor" of treatment. |
| Attack on Joseph Mackrill. Don't use Peruvian bark. |
| "I was . . . the only person in America who denied the contagion of the Yellow Fever." |
| Dr. Coulter lost but 8 of 300 cases using Rush's treatment. |
| Bled up to 130 oz. Used up to 356 grains calomel. Used jalop freely. |
| Report of 67 patients, treated without phlebotomy. 12 died. Against Rush's mode of treatment. |
| Commission of Health Report in regard to Health of Balto. Recommends quarantine and cleaning city of refuse. |
| Intermittents, Remittents and Yellow Fever are merely varieties of one disease. |
| On 9/17/1797 — a strong S.E. wind spread effluvia to Frederick, Gay, and Calvert streets and cases of malignant fever appeared there. |
| Yellow Fever in house with water in cellar. Two men who cleaned cellar both died of Yellow Fever. Innoculated suppurative material from Yellow Fever victim into his own arms without ill effect. |
| General report of Yellow Fever epidemic along East Coast. |
| In severe cases, nothing helps. "Commit the patient to the efforts of nature." |
| 164 patients treated with no mercury. Bark may be helpful late. Attack on Drs. Mace and Hayes. |
| Remarkable house-to-house epidemiological studies throw doubt on miasma theory. |
| Attack on Commissioners of Health for insensitivity to needs of the poor. Report of Medical Faculty on Yellow Fever in 1800. |
| 49 of 50 cases survived with the depleting (phlebotomy) method of Rush. |
| Defends his part in care of sick in epidemic. |
| "The . . . yellow fever, must be occasioned by eggs insinuated without our knowledge, into our bodies." (28, 29) |
| Description of epidemic. |
| Collection of official papers of Mayor on the Epidemic. |
| Reports of physicians and Medical Faculty on epidemic. |
| "The scroll of Fame shall transmit the name of Rush to after ages in imperishable characters." |
| Good description of Epidemic. |

were very rare only a few years past, when a far greater portion of Baltimore was a marsh."

Table 1 shows the published reports on epidemics of yellow fever in Baltimore between 1794 and 1819. Sporadic cases certainly occurred in other years, but often the disease was not recognized until an epidemic occurred.

* * * * *

The yellow fever epidemics of the late Eighteenth Century in Baltimore demonstrate the dynamics of response of the community to a new, strange, and fearful disease.[35] The Mayor usually turned to the medical profession for advice on whether an epidemic did in fact exist.[14,18,31,32] Official action in the form of ordinances was based on current medical beliefs that epidemics arose from rotting vegetable matter and swamps. Therefore appropriate action consisted of clearing the city of spoiled produce, draining swamps and cellars.[36] The appointment of a health officer and the establishment of a health department were some of the permanent advances made in response to the epidemics. Quarantine procedures were also put into practice, both by land and sea. As physicians observed the epidemics, there was a gradual change in opinion as to the contagiousness of yellow fever.

In 1793 at the time when Philadelphia was having a yellow fever epidemic, there was general agreement that yellow fever was transmitted by victims of the disease and from ships coming in from ports where yellow fever epidemics were present. More and more cases in Baltimore were observed without secondary spread to those caring for the patient, so there was a strong belief, gradually accepted by all physicians, that the disease was not passed from person to person.[1] By the end of the century, there were few who supported a contagious origin to the disease. Various ingenious explanations of how the disease originated were offered, generally well grounded in fact, but missing the part played by the mosquito. At least one authority mentioned the number of mosquitoes prevalent at the time,[2] but no one suggested a relationship between yellow fever and mosquitoes. In one ironic instance the Health Officer reports the danger of yellow fever to be over[37] on the same page with a facetious poem "To a Musquito." Mosquitoes were everywhere, but the connection with yellow fever was not to be established for a century.

The interest of the public is reflected in the newspapers of the day. Daily reports by the Health Department on number and causes of death in the summer and fall of 1802 were an attempt to present official information and pre-

vent rumors. There were a number of articles by physicians who presented their views on the origin of yellow fever. Such authors usually started their articles with the profession that they were acting in the public interest. More often they appear to be attempts at self advertisement.[6,12,21] Indeed there is one plea to physicians to report their information to the Health Department rather than to the newspapers.[32] Not all newspaper articles on yellow fever were written by physicians. One such article[39] suggests that an intelligent layman could comprehend the arguments of etiology of yellow fever as well or better than most physicians. This perspicacious article indicates that the medicine of the time was based on authorities and that practical clinical experience was as possible for the layman as the physician.

In at least one instance, a newspaper ran a long series on medical errors, a reprint from a Philadelphia newspaper ("A Solemn Warning").[40]

One Molieresque dialogue[41] between Betty (a nurse), a physician, and an intelligent layman reveals the obfuscation and confusion of the physician of the day. Such lampooning of the medical profession seems to have been unusual.

The professional attitude of physicians, as revealed both in professional and newspaper publications, was one of denial of epidemics, dogmatism in etiology, diagnosis, and treatment. Therapeutic activism was rampant, using drugs and procedures which, if not appropriate, were powerful and dramatic in action.

If one went to a physician, he could expect vigorous interventionist treatment. There was little expectant or observational approach. In view of the fact that physicians did not know the etiology of yellow fever, were unable to diagnose it except when far advanced, and had no effective therapeutic measures, it is a tribute to the hardiness of the human body that more patients were not killed by physicians.

## Available Drugs

In 1794, Arthur Canick, druggist, at the sign of the mortar, corner of Water and Calvert streets, advertised his products.[42] Many of the drugs were herbs (chamomile flowers, anise seeds, caraway seeds, aloes, oris root, sago, saffron, cloves, mace, cinnamon, juniper berries), a number of oils (Caster, Bright's, Harlem), and mixed tinctures ("the universal tincture, commonly called Red Bottle, a medicine of great use, famed for its extraordinary cures in England, of great use and efficiency for complaints in the stomach and bowels, all kinds of rheumatic pains, strains and bruises, burns, wounds, cuts, ulcers, toothache and scurvy").

Most of these preparations were probably ineffective and harmless. There were, however, a number of very powerful drugs, which were by no means harmless. These were the drugs widely used in yellow fever. The powerful cathartics, croton oil and jalop, were used in unbelievable doses. Mercury products were used to toxicity. Peruvian bark was effective against malaria, and there were some who used it in yellow fever[7] and others who did not.[8] Phlebotomy was used excessively in the early epidemics on the recommendation of that curiously wrongheaded charismatic physician Benjamin Rush, but later both mercury and phlebotomy were dropped.[21] Unfortunately none of these very powerful drugs and procedures were of any use in yellow fever.

## Denial of Epidemics

There were several reasons why physicians denied the presence of an epidemic of yellow fever so regularly and repeatedly. In the first place, the diagnosis often depended on a number of cases accumulating in a single physician's practice. Baltimore was the last large eastern seaport to develop, and the first yellow fever epidemic did not occur until 1794. Other towns had seen a number of yellow fever epidemics prior to this. Other fevers resembled yellow fever, and it was easy to assume that the disease was not yellow fever. Drysdale[2] recognized several early cases at Fell's Point in 1794, but could not get his respected mentor, George Brown,[3] to acknowledge it until the epidemic was in full swing. In fact, George Brown, John Coulter, and Lyde Goodwin formed a committee to investigate the rumor of yellow fever and concluded that the fever was really bilious remittent fever, that the deaths had been caused by a variety of different diseases, of which accidents, sun stroke and intemperance formed a large part.[3] On the same day, the Quarantine Officer, John Ross, reported that he had visited every ship arriving from sea and had seen no person with any kind of fever.[4] Two weeks later[5] the Baltimore Health Committee reported no yellow fever after a full inquiry.

A second reason for denying the presence of an epidemic of yellow fever seems to have been the fear of creating panic in the city, causing people to flee to the country, and interfering with the commercial life of the city through quarantine. A second form of denial was the belief that yellow fever was not contagious. If yellow fever were indeed not contagious, then leaving the city and enforcing quarantine were not necessary. In 1793 and 1794 most physicians, and certainly the mayor and citizens, believed it to be contagious. George Brown's statement that

yellow fever was not contagious was vigorously attacked by an anonymous critic in 1794.[6] By 1800 many physicians[9] had observed no cases of spread of the disease from a person with yellow fever and assumed that the disease was not contagious. Many still believed that it was somehow imported by ships from foreign ports.[21]

## Dogmatism

We have previously drawn attention to the vituperative and scurrilous exchanges between physicians in public in the eighteenth century in America. To some extent the dogmatism was an attempt to hide ignorance,[43] but there was also a malevolent grudge on the part of the European-trained physician with his MD degree against the local apprentice-trained doctor. The European physicians considered themselves an elite and lost no opportunity to attack the stupidity and boorishness of the native product.

One such controversy took place in the *Federal Gazette* in 1801 between Henry Stevenson[21] and A. Mace[24] The former was an Oxford graduate, a well-established Baltimore practitioner prior to the Revolution. He had been a British Army Surgeon in the Revolutionary War, but had returned to Baltimore and continued his smallpox innoculation practice at "Parnassus," his country estate. Mace was an apprentice of Dr. William Hayes. He had spent three years with him and had then attended lectures at Philadelphia, finally obtaining his license at Easton in June 1801.

Stevenson in an article ("Bilious, Putrid or Prevailing Fever") [21] presented his experience in the newspaper for the particular information of those who were unable to get a doctor, a shortage being evident even at that time. Stevenson believed the "remote" cause of yellow fever to be a moist atmosphere, and stagnant water, particularly in cellars. Spraying of the streets with water, good ventilation, and alcoholic spirits were recommended as preventive measures.

As far as "cure" goes, Stevenson comes out strongly against bleeding. He recommends cleaning the bowels with cathartics and the stomach with tartar emetic. Peruvian bark is recommended when the patient is improving because Stevenson recognized that intermittents (malaria) was frequently associated with yellow fever. Of 164 patients he lost only ten using no phlebotomy and no mercury. He believes that the fever may be imported, just as typhus was brought in by importing slaves and servants.

Stevenson's article is quite rational, recognizing the uselessness of heroic bleeding and mercury. He also recognized that yellow fever and malaria are different diseases and that they might occur together. Furthermore, he recognized that yellow fever might be imported, but did not think it contagious.

Several months later[24] Mace, in a polite letter, disagreed with Stevenson, stating that his cases were mild. Mace reported his experience with 50 cases, of whom 49 survived using the depleting method of Rush with repeated phlebotomy. Within two days (7/20/1801) Stevenson answered with a vituperative personal attack on Mace's ancestry, education, and preceptor, Dr. William Hayes, Jr. Stevenson accused Hayes of having fled from Fell's Point during the yellow fever epidemic in 1797. He then goes on to deny Mace's contention that yellow fever had originated in Dorchester County, claiming that all cases that Mace had seen had been in Baltimore prior to their disease.

On 8/26/1801, Dr. Hayes[26] notes that Stevenson has made free with his name and denies fleeing from Fell's Point, noting that the epidemic was over when he left. Hayes recommends the free use of phlebotomy. Added to the letter are affidavits from a number of patients seen in Dorchester County swearing that they had yellow fever.

Stevenson returned to the attack on 9/11/1801, repeating all his old allegations.

Looking back on this exchange from our present day, one is impressed with the correctness of Stevenson's position and his ability to draw the correct conclusions from a welter of conflicting evidence. One feels, however, that he was an irascible, unreasonable old man, using his position, superior education, and intellect to embarrass the locally trained doctors and build up his own ego.

Hayes, on the other hand, truckled to Stevenson, not daring to respond in kind, and opening himself to further vilification. That Mace was not silenced by Stevenson's attack is shown by an article ("A dissertation on yellow fever") a year later.[25]

A second newspaper controversy took place between a physician (Investigator) and Truth.[44] Investigator starts the controversy by reporting on the living condition of three sick people he has heard about. They have contracted a fever and live in poorly drained rotting housing which the landlord refuses to improve. A "Friend of Truth" replies on the following day that the conditions are not as bad as reported. A few days later Investigator demands an independent opinion. He notes that there are open water barrels in the yard. The people imbibe poison from the polluted air with every breath. He

notes that one patient's wife would not allow the patient to go to a hospital, and that the landlord would not allow him to visit a doctor because of fear that he would abscond and not pay his rent.

The next letter (from Truth) claims that the patient lives 100 yards from his property. Investigator then produces affadavits from the patient and from Dr. James Smith to support his allegations. Several more letters draw the episode to an unsatisfactory conclusion.

The interchange reveals many of the weaknesses of medical care and slum maintenance of the day. One suspects that James Smith, a notorious curmudgeon,[23] was behind this ill-informed and disorganized attack on a slum landlord.

## Therapeutic Activism

The yellow fever epidemics of the 1790s demonstrate a gradual change from the vigorous phlebotomy and use of mercury in the epidemic of 1794[11] to a more expectant and gentler approach by 1800.[21] This change represents a rejection of Benjamin Rush's recommendation drawn from the Philadelphia epidemic of 1793 as Baltimore physicians gained experience. There is some evidence that the more conservative school was supported by the physicians with European education. A second major change was from the view that yellow fever was contagious[4] to the view that it definitely was not.[32]

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# PSYCHIATRIC CONSULTATIONS IN THE EMERGENCY ROOM

JOSE M. ALBORNOZ-RUIZ, MD

*"My worthy friend, gray are all thoeries and green alone Life's golden tree."*
*Mephistopheles, impersonating Faust to a student.*
*Faust, Act I, Scene IV*

Psychiatric consultations in the emergency room are an expanding modality of professional practice for the modern psychiatrist. It would be difficult to trace this form of psychiatric intervention to its beginnings with any degree of accuracy, but it is probably safe to say that it developed in connection with the community psychiatry movement in the last decade. At any rate, gone are the days of the alienist, secluded in his country clinic, student and lord of the social outcasts of preceding centuries. Advances in psychiatry and irreversible changes in modern societies have placed the new psychiatrist astride the scientific progress in the physiological and biochemical workings of the mind as a function of the brain, away from jargon and mysticism. Yet, the Freudian warning that things psychological must be apprehended through psychological means remains as true as ever.

Therefore, in approaching the problem of psychiatric consultations in an emergency room, it appears desirable to make some general considerations to achieve a proper frame of reference in which the elaboration of fact, theory, technique, and opinion may produce insights of genuine clinical value. The concepts and ideas expressed in this monograph represent the experience of four years of doing psychiatric consultations in the emergency room, first at Sinai Hospital of Baltimore between 1966 and 1968, and then at Baltimore County General Hospital since 1969 to the present.

A perusal of the literature on the subject will show that in the absence of such context an inevitable emphasis results in statistical tabulations of limited value, or in overstructured versions about how to adapt or incorporate accepted psychiatric tenets into working techniques for management. It would appear that in either case a somewhat overwrought effort to make the clinical material into a scientific model results in an implied denial of the simple fact that a psychiatric consultation in an emergency room is not so much a scientific performance as it is a clinical act. The consultation is a highly visible example of the difference between medical technology as a body of scientific knowledge and medical practice as an age-worn Hippocratic art. The remarks of a geneticist seem a fitting keynote to this article. Dr. McKusick[1] states that "to the practicing clinician the question of whether a particular pathologic constellation is filed in the proper conceptual pigeonhole would appear as little relevant as the subtle taxonomic distinction between Pinus Strobus and Pinus Sylvestris would be to a practicing lumberman or carpenter."

Nowhere would this consideration find more appropriate application than in the context of the psychiatric consultation in an emergency situation, where the uncertain and vague nosology of psychiatric disorder must be used for a guideline in defining prognosis and treatment, without the benefit of an extended evaluation and with none of the externals that allow for a thoughtful and relaxed approach in the office situation. On the other hand, no rational intervention will be possible in the absence of a well-informed and scientifically grounded decision-making process. In its ultimate essence, the consultation in the emergency room must be at the same time a psychotherapeutic intervention, and psychotherapy is "an informed transaction that has a state-of-the-art and a technology." To intervene in such a situation without a keen awareness of such factor is truly "a travesty of decent psychiatric service."[2]

Studies carried out to determine the signifi-

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cance of psychological distress in medical patients have shown that "the doctor is not always sought as a medical expert, but also as a substitute affiliation in times of emotional loss, as an authority to sanction decisions which a person cannot make himself, as a confidant in a variety of situations, and as a mediator in many others."[3] This is particularly apparent in the emergency room, where the failure to identify these parameters in a crisis is an ever-present possibility, resulting in inadequate care if not in more serious and even fatal outcomes. In this context it is important to emphasize the concept of Parsons, who regards illness as a social role which defines appropriate behavior and obligations toward oneself and others, thereby acquiring a conceptual meaning well beyond what can be encompassed in a biological medical diagnosis.

In a very general manner, the psychiatric consultant in an emergency room would do well by substituting the question of "what disease does this patient have" with that of "what is the matter with this person," giving proper weight to the fact that "linguistic transaction is in fact a system of mutual expectations."[4] Therefore, more than a semantic game, it is the substitution of the aseptic language of scientistic—rather than scientific—medicine for that of the genuinely humanistic clinician that is achieved. In the language of the psychiatrist it could be said that by so doing the groundwork is laid for adequate structuring of the situation. In this new frame of reference there is no room for the all-too-familiar pronouncement "there is nothing the matter with him"; what remains is the difficult challenge of defining the patient's ailment in terms relevant to his own idiosyncratic way of expressing his needs. At this point, then, it becomes quite apparent that the consultation situation is a highly fluid, subjective, and unpredictable transaction in which factors other than the actual quality and nature of the patient's presenting psychopathology play a definitive role.

Any individual who reaches the psychiatrist goes through four milestones as he follows his path down to the psychiatrist. First, there has to be the abnormal behavior, and then there has to be the perception of his behavior as being abnormal. Then, there has to be an evaluation of this perceived behavior as either delinquent or disturbed."[5] This would appear as the most likely explanation for the variation in statistical figures as to frequency of psychiatric cases in emergency rooms, from 2.5% to 6% of the total visits for a given period of time according to different surveys.[6,7] What and whether to name a symptomatic constellation as a psychiatric disorder in that setting may not only depend on degree of psychiatric sophistication of the attending physician, but also on the degree of tolerance and receptivity to questionable forms of communication, both verbal and nonverbal, and on value judgments which even nowadays include a certain notion that a psychiatric intervention is both unthinkable or unacceptable to patients and/or doctors alike.

In the terms of a widely read book,[8] "The person labeled (as a psychiatric patient) is inaugurated not only into a role but into a career of patient by the concerted action of a coalition or a conspiracy of family, general practitioner, mental health officer, psychiatrist, nurse, psychiatric social worker, and fellow patients." It is beyond the scope of this presentation to examine the merits of such a position which is quoted only to emphasize further the peculiar dimensions of the consultation in an emergency room. The consultant must, therefore, encompass in his conceptual frame of reference a total outlook that allows for the synthesis of all the truly relevant factors—medical, social, emotional, and symbolic—conducive to effective grasp of the patient's situation and to appropriate management and recommendations. As a clinician, he should be aware that he must somehow find his way into the patient's underlying and sometimes unspeakable needs. As a consultant he has to realize that his intervention ought to result in an expeditious and useful resource to the emergency room staff. As a scientist he will do well in reminding himself about the inevitable limitations of the Art.

## Psychopathological Variables

I will now attempt a review of some of the situations under which psychiatric consultations are likely to be requested in an emergency room. The review is not intended to be exhaustive, because such situations actually encompass the total spectrum of psychiatric disorders from mental retardation to adjustment reactions of late life. Rather, it means to bring out some of the psychodynamic constellations that are more frequent and more troublesome to the consultant. It will be followed by a theoretical construct of my own regarding the dynamics of the consultation process and some of the pitfalls that should be avoided if the consultation is to have the desired impact.

Before getting on with the description of the phenomenological and dynamic issues involved in the consultation, it may be well to remember that in many cases the whole thing turns into a rather routine matter in which the psychiatrist simply endorses and confirms diagnoses and dispositions already made by alert and well-

informed colleagues. Every emergency room has its "repeaters" who simply show up to secure medical certificates and transportation to mental health facilities in the course of situations that may appear urgent and critical to almost everyone except the patient himself for whom the whole proceedings are a familiar, commonplace manifestation of a life-style. These may actually represent a pitfall for the unexperienced psychiatrist who, in his eagerness to be "involved," may generate friction and interference in the emergency room.

Following is a descriptive analysis of some of the most frequently encountered situations:

## I. Self-destructive Behavior

Self-destructive behavior is a manifestation of anger turned upon the Self. Anger is a very primitive emotional reaction in people that is better observed in its most uncontrolled fashion in the preschool child when he is having a tantrum; the physiological and behavioral responses in an angry child are a matter of everyday experience; the expression of the face, the extreme agitation of the limbs, the more or less destructive responses toward the environment are readily apparent. In the child, however, the actual physical possibilities for destruction and damage are so limited that no one gets scared. The child will be brought under control by a variety of means of coercion without responses of guilt in the parent. However, when an explosion of rage occurs in the chronological adult, the possibilities for injury and damage increase in direct proportion with the physical power of the person so afflicted, and the fear and counterforce generated in the persons that surround him. In general, anger gives an illusion of power, based on the shift from passivity and helplessness to activity.

On the other hand, an angry outburst, regardless of pejorative labeling as immature, neurotic, or psychotic is a source of power as a matter of fact. An angry person can modify a situation by virtue of the coercive effects of his rage on the environmental situation, but there is always the possibility of a devastating retaliatory blow. This gives the phenomenon of anger a socio-psychological dimension different and separate from its meaning as a simple psychological defense mechanism. It is precisely because of this that sometimes a paradoxical compromise is achieved in which this powerful emotion is discharged against the Self rather than against others, sometimes with unpredictable results. Two clinical configurations are common:

a) **The Suicidal Gesture.** As the name implies, there is no element of true suicidal intent. These patients, in discharging their anger upon themselves are not trying to kill themselves and do not mean to kill themselves. However, in the emergency room situation, they are assumed to be suicidal because of their self-assaultive behavior. Although a number of techniques have been developed to assess the lethality of self-directed aggression[8,9] none of them can substitute for the skill of the experienced clinician. However, there are certain features that can be helpful in the differential diagnosis. The suicidal gesture usually occurs in young people. The patient is angry and frustrated and will freely acknowledge that fact as well as the reasons for his resentment.

Suicidal behavior often is impulsive, poorly planned and executed, and there is usually a clear-cut target to the aggressive feeling. There is usually a clear manipulative intent. These are people whose family structure is usually intact; they show a reasonable level of achievement and vocational adjustment; and more often than not, they express regrets and shame about their sudden loss of self-control. This group also includes the mislabeling of accidental overdoses in people who may have used an excessive amount of medication by mistake when trying to sedate themselves, and who are whisked to the emergency room by an anxious relative or a well-meaning neighbor.

b) **The Suicidal Attempt.** Before setting down some guidelines for the identification of the true suicidal syndrome, it is important to emphasize the relativity of all generalizations in this particular context. Beall,[10] in a comprehensive review of the dynamics of suicide, points out that "suicide is not limited to depressive disorders, nor do all depressives commit suicide" in what amounts to be a clear refutation of commonly held notions. Several observations about the patient may contribute to a better assessment of the suicidal potential. The presence of a psychotic disturbance may result in suicide in a person who is in no position to measure the consequences of his actions, making the event a genuine accidental death.

Disturbances in thought process may be apparent in a number of ways, such as irrelevance or incoherence in the semantic component of the communication, or abnormalities in the behavioral and affective component. While the former are readily apparent to the nonpsychiatrist, the latter may be ambiguous and easy to miss. The patient may show inappropriate responses to the doctor, who may be belittled or criticized by the patient for no apparent valid reason. An attitude of hopelessness may find

expression in a peculiar disregard for the presence and activities of others. Unabashed, open admissions of guilt suggest a dangerous collapse of the usual mechanisms of denial, suppression, and projection by which this most painful emotion is usually controlled. A previous and extended psychiatric history should always be a source of concern. Older patients and displaced persons without interested relatives are a grave risk. Also, the self-assaultive behavior of the true suicide is truly lethal and often bizarre because of hidden symbolic connotations in which the suicidal act is an act of expiation or the symbolic murder of an internalized Other.

### II. Altered States of Consciousness

These are situations in which the patient is confused and disoriented as to time, place, and person. There is no question of peculiar, idiosyncratic symbolism here. While confusion and disorientation may emerge in the context of a psychogenic disorder in the generally accepted sense of the term, more often than not they are related to severe metabolic disturbances in the central nervous system. From this viewpoint, mental status has been considered "one of the clinical barometers of cardiac function,"[11] and, indeed, it is one of the most sensitive indicators of the breakdown of homeostasis in many different kinds of systemic illnesses. Here the critical challenge to the psychiatric consultant is that of recognizing the associated medical disorder, perhaps missed by a hasty colleague who may have felt that this was a psychiatric case because of the mental status findings.

In this context, it may be helpful to remember that confusional states related to depressive-hysterical neurosis, particularly in cases associated with borderline mental retardation, are quite similar to those seen in patients with cerebral ischemia, whether central or peripheral in origin. This is particularly important when dealing with the elderly, in whom cerebral circulatory changes are more common but, of course, do not rule out or exclude an underlying psychogenic disturbance. The possibility of a toxic state associated with drug abuse must also be considered, particularly in younger people. Special attention should be given to states of confusion with clear sensorium, rather characteristic of the Korsakoff syndrome in patients with long-standing histories of alcoholism. States of altered consciousness related to epilepsy are often easily recognized on the basis of the clinical history.

### III. Assaultive and Belligerent Behavior

This type of situation presents many complicated variables to the consultant. The unrestrained expression of anger towards others usually has ethical and legal connotations. It is a relief of the collective conscience of society to label violent, morally unacceptable behavior as "sick" behavior. This pejorative approach finds paradigmatic expression in patients that are taken to the emergency room following an explosion of anger in the context of a marital argument or some other similar situation. In naming the angy outburst "sick," a smoke screen is cast over the ethical and legal issues involved; thus labeling serves as a rationalization for everyone concerned. It would appear as though some states of rage are holy, while others are just "sick." From a psychiatric viewpoint, however, the phenomenon can be looked at only for what it is, and for what it means to the patient and to others, especially from the viewpoint of dangerousness to life, limb, and property.

Paranoid states are commonly seen in this connection. While the psychiatrist has little difficulty in recognizing this disorder, these cases are likely to present many problems to the staff in an emergency room. The paranoid patient often shows no gross indication of confusion and his communication can appear to the inexperienced observer as objective and to the point. Quoted from a medical record is this statement, "This lady is paranoid enough to realize that she is not that crazy." It is said in psychiatric circles that a paranoid person is one who has all her facts right and all her conclusions wrong. This is generally so because of the way in which she integrates her experience in terms of her own subjective feelings and needs. The French used to call this disorder "follie raisonante" precisely because of the inner consistency of the patient's logic. It is for the consultant to decide whether such a state is a manifestation of an underlying schizophrenic disorder, or the expression of an anxious state in a paranoid personality. There are usually other parameters that allow for the distinction.

Instances of violent behavior are also seen in cases of alcoholism and epilepsy but in such cases the history is clear-cut and helps a great deal in the differential diagnosis. Aggressive behavior in the mentally retarded usually presents no diagnostic problems.

At any rate, I am under the impression that in most cases aggressive and assultive behavior is actually reactive behavior, directed towards the meaningful Other in the patient's life, and tends to subside as soon as the patient recognizes the therapeutic intent in the environment.

## IV. Odd and Unconventional Behavior

Not infrequently the consultant gets called about patients who seem to act strangely around the emergency room, or who may have been referred to the emergency room from other areas of the hospital. They do not seem able to state a complaint, or make unusual requests. This type of mental disturbance is often seen in connection with chronic psychotic conditions or hysterical dissociative states. Although they represent no acute emergency as such, they are often turned into one because of the lack of sensitive management. Proper recognition of the situation for what it is results in significant gains for the emergency room staff in terms of avoiding unnecessary tests and waiting, and expediting the referral of the patient to the proper sources of care.

**Consultation Process.** Turning our attention to the group process in the consultation, it seems important to bring out several points. "To leave the conceptualization of the consultation process to the private discovery of the resident, without supervision and guidance, makes as little sense as to say to him to conduct group or individual psychotherapy without learning the appropriate theoretical framework."[12] The psychiatric consultant should be aware that he, as a person and as a professional, is a very substantial factor in what develops. If he manages to do what is appropriate, the issues raised and the emotions aroused around the consultation situation will come to an orderly resolution, without undue harassment or discomfort in the majority of cases. It is important not to feel obliged to respond to the occasional needle or wisecrack of the nonpsychiatric staff whose motivations are not the case to explore at the time of the consultation. Nor is the consultant to become an unsolicited teacher to the colleague whose attention is usually taxed with other responsibilities in the emergency room area. He must, indeed, recognize the mistakes that might have been made in the management of the situation prior to his arrival for the purpose of allaying anxieties and hostilities that may interfere with his duty to the patient and to the staff he is supposed to consult for.

I have classified the consultation process in a four-stage manner, which I believe reflects the natural course of events in nearly every occasion as follows:

**1) Evaluation and structuring**
**2) First Impact**
**3) Confirmation**
**4) Resolution**

**Stage I—Evaluation and Structuring**

The consultant must become thoroughly conversant with the facts of the situation prior to seeing the patient. A review of the emergency room protocol saves a lot of unnecessary questions and allows the synthesis of observations and comments from the emergency room staff members; that provides sufficient guidelines as to what to look for in the interview. Then, as the interview begins at the bedside, it is important to remember that the patient should be given the opportunity to set the pace; as opposed to the office situation, the patient should be allowed to structure the interview. At this particular time "the equanimity, calmness, and composure of the physician is his single most valuable asset."[13] It should be remembered that in his particular predicament, the patient is truly regressed, in a volatile emotional state, and quite unable to tolerate any frustration.

In addition, he may be reluctant to talk because of previous mismanagement by the emergency room doctor who through paternalistic, jocular, or overanxious approaches may have led the patient into a defensive withdrawal. Regressed as he may be, the patient fortunately can still mobilize his own ego resources. He has his own experience and knowledge and is quite capable of detecting untoward attitudes in the doctor which may interfere with his responding to the situation in the way that may be desired. The point is cogently illustrated by a remark made by a patient who once told me, "If nothing else, all these years of psychiatric problems have taught me to recognize a friend when I see one." One minor, if significant, manifestation of concern and interest by the consultant has to do with recommending, in agreement with the attending staff, the removal of I.V. fluids, urethral catheters, tight restraints that might have been very well advised several hours before, but which by the time of the consultant's arrival amount to nothing other than mild forms of torture that usually are permitted to last longer than necessary.

Another point has to do with management of relatives. It must be kept in mind that very often a hidden drama—sometimes a comedy—is under way, and that much of what the patient says and does is intended to be seen and heard by the relative. Therefore, it is important to separate them during the interview, carefully avoiding to take sides in any controversy. The consultant must not be afraid of the patient. Talking to people who have been through the painful and bewildering experience of undergoing a psychotic state, I know the impact of the reassurance of an understanding doctor who is capable of responding to the vestiges of ration-

ality left in the patient without being overwhelmed by the uncertainties and fear of everybody else around him. The feelings and working habits of the emergency room staff must be kept in mind. The emergency room can become, at times, the setting of frantic activity which creates a hectic atmosphere where the pipe of the psychiatrist becomes curiously irrelevant if not downright offensive to the rumpled and harassed staff.

#### Stage II—First Impact

As with any other theoretical scheme, this one attempts to present separately things that are actually developing simultaneously or in very close succession. For the patient, the information that he is going to be seen by a psychiatrist often amounts to the equivalent of a subcutaneous injection of adrenalin, particularly when it happens for the first time. In some cases, it begins with the awed, avoiding response of a staff doctor or nurse who, after a couple of sentences to the patient, blurts out a pronouncement that the patient must be seen by a psychiatrist, in what amounts to the patient as a crude verdict of insanity. Or he can sense that his complaints or requests are being questioned, ignored, or misunderstood. But even when the staff is sensitive and tactful, and when the patient seems to be thoroughly rational, he still seems to feel that his rationality is put to test, to say the least. The consultation is accepted in the spirit of a veritable defeat.

As for the relative, he may be loath to the inevitable questions and confrontations that may be expected when the consultation takes place. Depending on the situation and what it means to the patient, he may respond by becoming even more agitated, angry, or confused. Conversely, he may settle and calm down in those cases in which he feels a desperate need for someone who will understand. From a certain viewpoint, it would be highly desirable if the doctor in charge could envision the patient's mental status with the same degree of objectivity that he looks at his electrocardiogram. This, however, is not possible because the patient's emotions create around him a great degree of affective resonance which interferes with the professional's critical faculty in a way that could be appropriately compared with the effects of a highly charged electromagnetic field on a radio signal.

In the context of this first impact, it is important to realize that the cubicle in which a patient is observed in an emergency room is an almost ideal place to carry out acts of self-assault. There are often pieces of tubing, first aid trays, and other implements which can be easily used as weapons. I still remember the case of a young woman who, while being restrained, removed a pair of scissors from the uniform pocket of one of the staff nurses. She later attempted to use them against the personnel when the time came to transfer her to a psychiatric hospital. Fortunately no one was hurt. It is, therefore, important to remind the nursing personnel that if the patient is suspected of being psychotic or appears confused, he must be maintained under direct and continuous visual supervision until the situation is under control. This is a fundamental aspect of the consultation.

The control of the patient's response during this stage begins with proper reassurance. Very often, the patient's recognition that what is being done is helpful and relevant to his needs prompts him to mobilize the healthiest aspects of his personality in order to help his helpers. However, sometimes it does not work that way, particularly when the patient is very sick or drunk. In those cases, the consultant must be able to take command of the situation, without guilt, without embarrassment, and without hesitation. It would be apparent that the consultant's source of authority in such situations is particularly strong, on a twofold basis—transferentially, because the patient, regressed as he is, responds to him as if he were his father, and actually because for the time being the consultant is the person in charge. In such instances it is appropriate to demand that the patient behave, and it is no surprise to the well-trained psychiatrist that even violent and psychotic patients show an abrupt change of attitude and a more cooperative disposition. This depends, basically, on the character and forcefulness of the psychiatrist, but chances are that somewhere along the line the patient will hook on, so to speak, to the therapeutic intention. I believe that, except for very rare cases, a patient's assaultive behavior toward the doctor is related to errors in the doctor's technique. At the time of this kind of crisis the patient's self-esteem is at a very low ebb and even trivial acts of tactlessness may be construed in the patient's mind as offensive or unacceptable, with unpredictable consequences.

#### Stage III—Confirmation

After the psychiatric consultation reaches the point of offering the first alternatives—discharge from the emergency room with extended evaluation later on, hospitalization, certification, etc—the human drama that is unfolding, hopefully under the guidance of the consultant, comes to a climax of sorts. Relatives and other interested

persons may want to talk with the consultant to size up the implications of his determinations. The patient will want to see his relative. Brief conferences develop that may, from moment to moment, change the course of events. In short, a variety of psychodynamic forces are set into motion, which get further organized and systematized at a quickened pace in the minds of the patient, his relatives, or relative-surrogates, such as social workers, welfare workers, and others that may be directly involved in the outcome.

The consultant must answer many questions and study a number of alternatives. These situations are confusing precisely because everyone, the patient included, is right. The psychiatric consultant must then remain a flexible catalyst, an orchestra conductor as it were, whose hesitation and doubt must be shared with the patient and his family so that the crisis may come to a satisfying professional and human settlement. A dogmatic attitude in the consultant is a sure recipe for failure. I find it helpful to apply here a line of Hegelian dialectic, according to which the purpose of discussion and argument is to make explicit all that was implicit in the partial views. The consultant must remind himself at all times that there are usually underlying factors motivating the patient and his family that he probably does not know and cannot expect to know in the emergency room situation. In consideration of the high demands that the role places on the consultant, it seems advisable to have a rotating schedule where all available staff psychiatrists may participate. I do not believe that placing a professional person in charge of the management of crises situations on a routine basis every day of the week is technically sound or psychiatrically defensible.

When psychopathology is truly severe and malignant, Stages I and III evolve without bringing about any significant change in the consultant's conception of what the problem is and what needs to be done. In such cases, it appears quite clear that the only course of action consists in ongoing evaluation and treatment in an inpatient psychiatric setting. Dynamically, this implies that the patient's ego resources are so inadequate that he cannot measure up to the demands of the crisis, and a total psychological breakdown ensues. On the contrary, in milder cases, the therapeutic aspects of the consultation—catharsis, clarification, redefinition, confrontation, support, and counseling—allow for the crisis situation to ease up, and a number of elective alternatives can be suggested for further implementation after the patient is released from the emergency room.

**Stage IV—Resolution**

This part of the process is concerned with the procedures evolved in cooperation with the emergency room staff for the purpose of securing rapid implementation of decisions made during the consultation. These have to be worked out with imagination and originality on the basis of the size and resources of the emergency room. The nursing staff ought to be conversant with all administrative steps necessary for psychiatric hospitalizations. Close liaison needs to be developed with psychiatric back-up facilities in the area. The consultant must stipulate clearly in his consultation note his recommendations, especially in reference to the use of medication while the patient remains in the emergency room area, and all other loose ends that may be the case, such as manner of transportation if the patient is to be transferred out of emergency, or sources of referral and continuing care if the patient is to be discharged. In this connection, it is also important to educate the emergency room staff on the question of discharge against medical advice. It should be emphasized that in spite of every effort, the consultant seldom gets to the bottom of the story as it unfolds in the emergency room.

As far as the patient goes, in a large proportion of cases, the whole question of being the object of a psychiatric consultation is just an unthinkable and intolerable interference with his life. He is often supported in such a view by his family and relatives. He is just as confused as some doctors are by the dichotomy of what is "physical" and what is "mental," and he will simply refuse to cooperate in any way besides his perfunctory aquiescence to talk with the consultant. Such cases always present delicate quandaries of a legal nature, particularly when, in the consultant's opinion, a restriction of the patient's freedom is mandatory. In the more serious cases, this kind of situation requires the intervention of a Court of Law, and the consultant would do well in having very solid grounds before he orders or recommends the retention of a patient on the premises against his will. Sometimes we simply cannot help.

However, it is important to recognize that an otherwise neat professional intervention can be marred by inadequate follow-through by the emergency room staff. Lack of decisive, clear-cut follow-through, brings back elements of uncertainty and suspiciousness that may in fact destroy the therapeutic impact of the consultation. The fact that so many emergency rooms provide services to psychiatric patients without the benefit of having psychiatric consultations is to my mind sufficient empirical demonstration of the

gradual overlapping of the functions of the physicians-in-charge with those of the psychiatric consultant when it comes to the management of the particular form of human suffering presented by psychiatric disorder. It is, indeed, a demonstration that common sense and compassion are by no means traits unique to the well-trained psychiatrist.

There is always a gradation of levels of care from the essential to the ideal. The patient can be trusted to produce his own original ways of coping with his conflict, which in the emergency room encompass the varying degrees of adequacy or inadequacy of services offered him in his moment of distress. Things will always work out, but for the practicing clinician it is the how and what of the emergent alternatives which define the relative merits of his intervention. The psychiatric consultant is presented with the challenge of helping people at a moment of their lives in which their need is understood by few and properly handled by less. An acceptable outcome against such odds is a highly gratifying experience.

### Summary

1) General considerations concerning psychiatric consultations in an emergency room as a newly emerging form of professional experience are made.

2) Some forms of psychopathology as they present in the emergency room settings are highlighted with some suggestions relative to management.

3) A theoretical scheme dividing the consultation process in four stages is advanced for the purpose of decreasing the unpredictability of what is discussed as a highly fluid and unpredictable transaction, full of potentials for miscarriage and inadequate management.

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## Health Care Systems

The 1972 president-elect of the American Hospital Association sees early changes in the health care delivery system that will stress health maintenance and conserve health dollars for the individual.

John W. Kauffman, executive vice president of the Princeton Hospital, Princeton, NJ presents his views on the health care delivery system in the January 1 issue of *Hospitals, Journal of the American Hospital Association.*

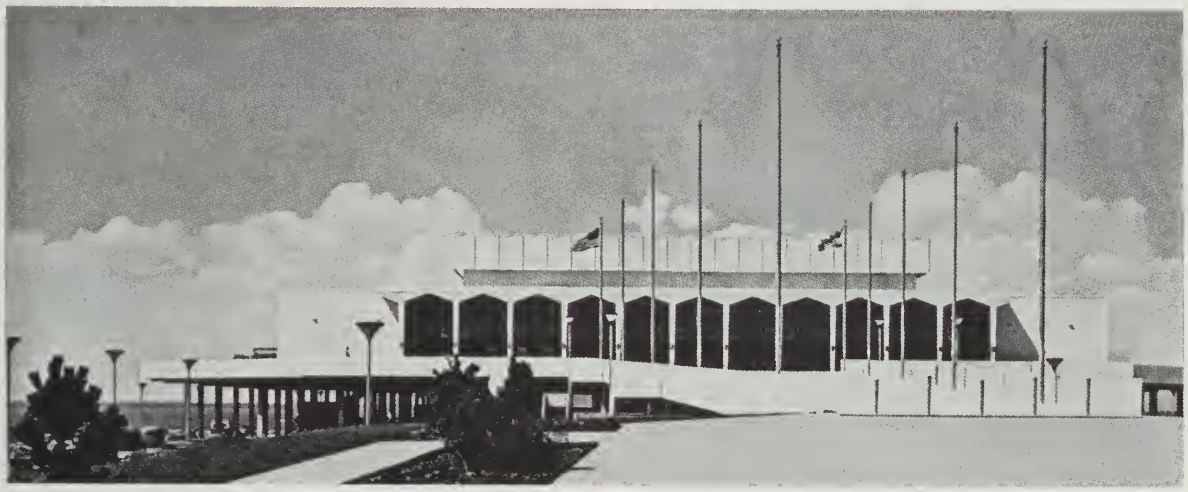
Mr. Kauffman suggests that health care dollars can be spent in a different way "to reduce the incidence of general hospital admission by concentration on health maintenance.

For many years the general hospital has been overutilized (some patients have been kept in the hospital bed too long and others shouldn't have been there in the first place), Mr. Kauffman said. He advocates the expansion of extended care facilities to reduce the direct cost to the individual, and the use of these dollars in health maintenance programs. "This is where the delivery system is going to change," Mr. Kauffman said. "As a hospital administrator, I can't change this. The only way it can be changed is through working and obtaining the understanding and willingness of the medical profession. I'm not sure how we can do that, but I think it will be through a continuing education effort. The nation doesn't have unlimited dollars for health care, and we must find a way to spread them around and do a better job with them."

Mr. Kauffman assumes the office of president of AHA on Jan 1, 1973. The 1972 president of AHA is Stephen M. Morris, president of the Samaritan Health Service, Phoenix, Ariz.

# SEPTEMBER 14, 15, 16, 1972
# SEMIANNUAL MEETING

**Medical and Chirurgical Faculty of State of Maryland**



Unless otherwise indicated, all meetings will be at the Convention Hall, 4000 Philadelphia Ave, Ocean City, Md

**PROGRAM**

## THURSDAY, SEPTEMBER 14

7:00 PM ORAL HYPOGLYCEMIC AGENTS: THEIR PRESENT ROLE IN THE CONTROL OF DIABETES

and

MODERN CONCEPTS IN THE TREATMENT OF JUVENILE DIABETES

Speakers to be announced

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## FRIDAY,SEPTEMBER 15

7:45 AM Continental Breakfast
Reservations REQUIRED — contact Faculty office

8:30 AM Parliamentary Briefing Session

9:30 AM Meeting of the House of Delegates

9:30 AM Meeting of the Woman's Auxiliary

12:30 PM MMPAC LUNCHEON — reservation form mailed under separate cover

A YEAR OF DECISIONS
**William H. Cooper,** MD, Washington, DC

2:15 PM THE ROLE OF CORONARY ARTERIOGRAPHY IN THE DIAGNOSIS AND TREATMENT OF CORONARY DISEASE

**Herbert L. Abrams,** MD, Cook Professor and Chairman, Department of Radiology, Harvard Medical School

PANEL DISCUSSION to follow

Moderator

**John B. Hearn,** MD, Department of Radiology, St. Joseph Hospital, Towson, Md

Participants

**Vincent L. Gott,** MD, Richard Bennett Darnall Professor of Surgery, The Johns Hopkins University School of Medicine

**Leonard Scherlis,** MD, Professor of Medicine and Head, Division of Cardiology, University of Maryland School of Medicine

This discussion will concern itself chiefly with the indications and usefulness of BYPASS SURGERY in coronary diseases.

6:30 PM RECEPTION AND BANQUET

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## SATURDAY, SEPTEMBER 16

10:00 AM ADVANTAGES AND DISADVANTAGES OF NEUROLOGICAL CONTRAST STUDIES

**John O. Sharrett,** MD, Instructor in Neurosurgery, University of Maryland School of Medicine

11:00 AM MEDICAL MALPRICTICE: NO FAULT OR OUR FAULT?—A panel discussion

Moderator

**W. Kenneth Mansfield,** MD, Chairman of Committee on Medical Economics, Medical and Chirurgical Faculty

Participants

**John F. King,** Esquire

**Jonas R. Rappeport,** MD, Psychiatrist for Supreme Bench of Baltimore

**Verne E. Brown,** Assistant Secretary, Home Office Claim-Loss Division, St. Paul Insurance Company

1:00 PM CRAB FEAST — Phillips Crab House

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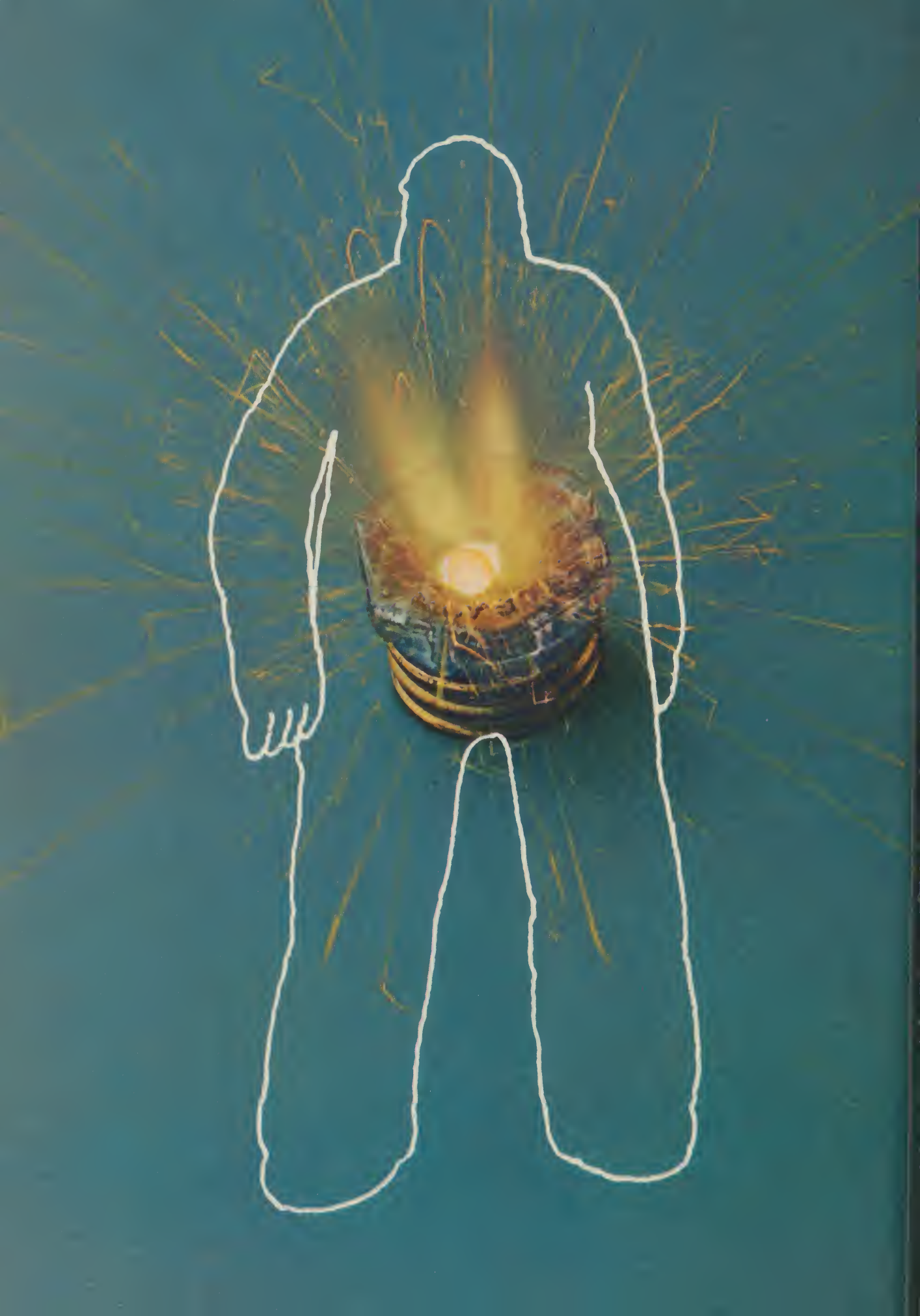
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# Arbitration of Medical Malpractice Claims

JAMES G. ZIMMERLY, MD, JD, MPH, FCLM, FACPM

A great deal has been written about the malpractice crisis in recent years. The effects of the crisis, whether imagined or real, in terms of defensive medical practice, higher cost of care, or dearth of insurance companies willing to underwrite malpractice insurance are debated daily. Within recent months the medical and legal professions have seen the appearance of new methods of resolving medical malpractice claims. One such method is arbitration of claims in place of the familiar, albeit much maligned, jury trial system.

Recently, Maryland Congressmen Gilbert Gude and Lawrence Hogan and Virginia Congressman Joel Broyhill introduced H. R. 14038, which, if enacted, would require arbitration of all medical malpractice cases in Washington, DC. This latest, most drastic of all legislative forays into the problems of malpractice litigation would affect Maryland and Virginia physicians having a practice in the District of Columbia as well as those practicing solely in Washington, DC.

**The bill provides, among other things, that:**

1) All medical malpractice cases be tried before a board of three arbiters.

2) The plaintiffs select one arbiter, the defendant selects one arbiter, and the Chief Judge of the Superior Court selects the third.

3) If either party fails to select an arbiter within 14 days of the date suit is filed, the Chief Judge selects for that party also, so that delay is impossible.

4) The arbiters be selected from lists supplied to the Superior Court by the various professional associations in the Metropolitan DC area. The idea is to have professional persons hearing cases involving professional persons.

5) The arbiters serve without pay and each arbiter hears no more than one case per year.

*From the Legal Medicine Section, Armed Forces Institute of Pathology (AFIP), Washington, DC 20305.*

*Dr. Zimmerly is chief, Legal Medicine Section, AFIP; also associate professorial lecturer in forensic medicine, George Washington University.*

*The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.*

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6) No more than two of the three arbiters may be from the same profession.

7) At least one arbiter be a lawyer and that he serves as Chairman of the Board of three arbiters.

8) A majority vote be sufficient for all matters before the Board.

9) Fees for attorneys representing clients in cases before the Board be limited to 25% of any award on a contingency fee basis. This is quite sufficient since the preparation of cases and trial time should be markedly reduced by the arbitration process.

10) The procedural rules and rules of evidence be very informal.

11) The arbiters determine the amount of damages as well as liability.

Why are some physicians interested in removing malpractice litigation from the courts?

**Malpractice litigation has a number of adverse impacts that provide independent justification for modifying the law of medical malpractice.**

1) It induces the practice of defensive medicine.

2) A substantial and often undeserved stigma and trauma are imposed on the defendant physician. The long-term adverse effects of this impact, while perhaps not substantial, may not be justified by the limited gains from malpractice litigation.

3) Malpractice litigation imposes tremendous administrative costs on the health-care system in discovery costs and attorney and court fees.

4) For these costs, malpractice litigation makes only a questionable contribution to the maintenance of an acceptable standard of care, and it spreads the costs of only those injuries received by those few patients who win malpractice cases. It is very doubtful that the limited beneficial effects of litigation of malpractice suits are worth the present cost.

5) Physicians resent the judging of their medical conduct by a panel of laymen who they feel are inherently sympathetic towards plaintiffs of their own social class and economic standing and unappreciative of the uncertainty and risk involved in medical practice.

6) Physicians distrust the adversary system as a means of arriving at objective fact. Doctors

generally hold in disdain the practices of attorneys in manipulating facts; attempting to thwart the admission of evidence; and invoking the sympathy, prejudice, and emotions of juries.

They look with particular contempt at the emerging doctrine of "res ipsa loquitur," which is vigorously criticized as being an artificial means of proof, subject to misapplication and abuse. Physicians call it "res slipsa to us."

In addition to the financial effects of adverse judgments and increased insurance rates, the medical profession always points to the damage to doctors' reputations and to effects upon medical practices as being unjustified and dangerous consequences of the present court trial system.

**What are the advantages of arbitration, as far as physicians are concerned?**

1) There is more privacy to the defendant doctor. There may be no transcript of the hearing unless requested by one of the parties. Even then, it is not published as are court decisions. Private arbitration does away with the "flamboyant" aspects of many jury trials.

2) Both sides benefit from a speedy disposition of a case, whether it be malpractice or other.

3) The arbitration hearing is normally of much shorter duration than a court trial would be. In arbitration, disputes can be resolved expeditiously. Removed from the scene are the procedural rules and motion practice, so susceptible of producing delay. Without strict adherence to the rules governing the reception of evidence, the hearing can proceed quickly to a just determination. It is also possible to get into the hearing and through it much more expeditiously—30 to 60 days rather than one to five years awaiting trial, and one to four days rather than several weeks disposing of the case once the hearing begins.

4) Arbiters, being professionals, are less susceptible than a jury of lay persons would be to the high awards in cases of minimal injury. Some jury verdicts are completely out of line with the damages in the case. The evidence in a medical malpractice case is often very complex. A jury of three experts would, it is hoped, possess the skill and background to interpret the evidence correctly—more so than a lay jury, who require a lengthy education during each trial.

5) Both plaintiff and defendant lose by the lengthy delay (perhaps one to five years) before trial begins. After that there may be additional delay pending appeals. Even when the physician defendant wins in these long-drawn-out cases, he still loses something.

6) Another advantage of arbitration is that the motivation for settlement occurs shortly after the claim is filed; ie, in a matter of mere months. The eve-of-trial point would be reached only after years if the same case had to take the litigation-in-court route.

7) The tremendous reduction in the cost of carrying a claim through arbitration as opposed to a full-dress court trial should not be overlooked. Arbitration must have an effect on keeping the cost of malpractice insurance down to obtainable limits because doing away with lengthy court trials will do away with up to 50% of the cost of malpractice claims. This cost is in investigating the claim and preparing for and conducting the trial of the case.

**What are some advantages of arbitration as far as the plaintiff is concerned?**

1) For one thing, the patient may present textbook evidence. He does not have to produce medical experts in person, although he may if he desires and can locate one.

2) Generally, hearsay evidence is permitted, although the arbiters give it an appropriate amount of weight. If there is one aspect of arbitration that is guaranteed to cause an attorney to reach for his favorite tranquilizer, it is the relaxed rules of evidence that arbitration employs. Many attorneys, trained as they are for the formal rules to be found in the courts, find traumatic the informality and permissiveness of the arbitration hearing room. Even some of the most experienced advocates feel unhappy when the arbiter agrees to accept certain kinds of evidence that a court of law might reject as irrelevant.

It has been suggested that attorneys have adapted to arbitration in countless other types of cases, so they can do the same with medical malpractice claims if they will accept the advantages of the arbitration process.

3) Arbitration may well be a substitute for litigation. But there are occasions when the right to sue is more illusory than real and when arbitration represents not the substitution of one right for another but the acquisition of a new right. It does not do the potential plaintiff any good to have a right to bring suit against a tortfeasor if he cannot find an attorney to represent him in the case. Very few attorneys, in even our largest cities, are compentent or possess the time it requires or the interest to litigate a complex medical malpractice case successfully. This guarantees that the small claim will not be litigated.

One of the advantages (or disadvantages, depending on whether you win or lose in arbitration) is the finality of the decision. The arbiters'

decision normally cannot be appealed except for an extremely narrow scope of reasons: if they are guilty of fraud, or refused to hear one or another of the parties, or held a hearing when one of them could not attend, or refused to give some evidence.

Judicial review of an award in arbitration is normally concerned only with defects in the arbitration procedure, not with the sufficiency of the evidence or the merits of the award. The arbitration award may not be impeached because of alleged errors either of law or of fact.

Unfortunately, H. R. 14038 as introduced would allow an appeal based on the sufficiency of the evidence. This could tend to negate all of the advantages of arbitration by permitting the plaintiff to retry his case in a court of law. Many attorneys will find this provision to their liking. It has the effect of making the arbitration hearing a mere discovery proceeding for the plaintiff.

**What are some of the disadvantages of arbitration?**

As far as the physician is concerned, arbitration may well result in more claims being filed. Many malpractice cases are turned away by attorneys because they are too small to be worth the tremendous effort and aggravation involved in litigation. In addition, few attorneys possess the requisite expertise to handle a complex medical malpractice case. Arbitration—by demanding little expertise, by relaxing the rules of evidence, and by insuring rapid review of the claim by impartial experts, including physicians—may well result in more claims being filed. This may be a disadvantage of arbitration to the physician but not to the aggrieved patient whose claim was too small to attract a competent attorney to handle it under our present system.

It is significant that a number of prominent plaintiffs' attorneys, including Albert Averbach, favor arbitration of malpractice cases. Mr. Averbach, who has tried as many malpractice cases as any attorney and who has been eminently successful, has claimed for years that malpractice cases do not belong in the courts. Other medicolegal authorities, including David Rubsamen of California, have long advocated arbitration as being one possible solution to the malpractice litigation problem. A number of California hospitals are currently experimenting with voluntary arbitration.

Whether one agrees or disagrees with arbitration, the California experiments, H. B. 14038, and others demand that the medical profession, the legal profession, the insurance industry, and the public let their feelings be known.

The choice is clear. The medical and legal professions either experiment with new forums or practices or live with the old court trial and end the complaining about its deficiencies.

It may well be that the worst settlement under arbitration may be better than the best law suit.


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# LYMPHOCYTOPENIA IN MALIGNANT DISEASE

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**Department of Medicine**
**Mercy Hospital**
**Baltimore**

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The factors which control the number of lymphocytes in the peripheral blood are ill-defined and poorly understood. Elevations in the total lymphocyte count are frequently noted in certain types of infections, and much clinical significance has been attributed to this occurrence. Lymphocytopenia, however, has attracted far less attention, perhaps because the clinical or diagnostic significance of a reduction in the number of circulating lymphocytes is not clear. In fact, the functions of the lymphocyte itself have not been well delineated.

Lymphocytopenia has been associated, to a greater or lesser extent, with a number of conditions (Table 1). This listing includes such commonly observed conditions as congestive heart failure and tuberculosis, and also more esoteric states such as that following chronic surgical drainage of the thoracic duct and the administration of anti-lymphocyte serum. In most of these conditions, lymphocytopenia is not a constant finding, and the relationship between the disease state and the occurrence of lymphocytopenia is often obscure.

**Table 1: Conditions Known to be Associated with Lymphocytopenia**

| |
|---|
| Congenital Immunologic Deficiency Syndromes |
| Hodgkin's Disease |
| Acute and Chronic Uremia |
| Therapy with Steroids, Ionizing Radiation, Cytotoxic Agents |
| Acute Infection |
| Tuberculosis |
| Lymphosarcoma |
| Agranulocytosis |
| Systemic Lupus Erythematosus |
| Exhaustion |
| Congestive Heart Failure |
| After Abdominal Catastrophes |
| Burns |
| Jaundice |
| Electric Shock |
| Pyridoxine Deficiency |
| Carcinoma |
| Chronic Thoracic Duct Drainage |
| Mongolism |
| Prolonged Anesthesia |
| Administration of Anti-lymphocyte Serum |

There are only a few studies in the literature which have attempted to document lymphocytopenia and correlate this with disease states. In 1950, Shillitoe[1] studied 87 patients in whom peripheral lymphocytes numbered less than 1000/cu mm and found that 20 of these patients had cardiovascular disease and 15 patients had malignancies. In 1966, Hurdle, Gyde and Willoughby[2] studied 56 patients with lymphocytopenia and found congestive heart failure to be the most common diagnosis. A group of ten patients with congestive heart failure was found to have significantly lower total lymphocyte counts than an age-matched control group.

Krant and his colleagues[3] in 1968 studied a group of patients with bronchogenic carcinoma as well as an age-matched control group, and found that the cancer patients exhibited a marked decrease in their ability to demonstrate a delayed hypersensitivity reaction, as manifested by skin reactivity to dinitrochlorobenzene (DNCB) and PPD. When the total lymphocyte counts in these two groups were compared, it was found that the cancer patients had significantly lower counts than the age-matched controls. In fact, the mean total lymphocyte count for the malignant group was about half that of the control group. This decrease was correlated with the decreased reactivity to DNCB and PPD. It was also noted in this study that circulating lymphocyte counts decreased significantly as the patient approached death.

In 1971 Zacharski and Linman[4] published an extensive study which again pointed to a relationship between low lymphocyte counts and malignancy. These authors identified 178 patients with both relative and absolute lymphocytopenia, defining relative lymphocytopenia as having fewer than 15% lymphocytes on peripheral smear, and defining absolute lymphocyto-

penia as a total lymphocyte count of fewer than 1,000 cells per $mm^3$.

Of this group of 178 cases of lymphocytopenia, 43% were found to have malignant neoplasms. When those patients receiving therapy with steroids, immunosuppressive drugs or ionizing radiation were excluded, malignancy still remained the most common disease diagnosed, accounting for 22% of the patient group. A comparison was then made between lymphocyte counts on 510 healthy subjects and 227 patients with untreated gastrointestinal malignancies. Of the patients in the malignancy group, 22.4% had total lymphocyte counts less than 1,000 cells per $mm^3$, while only 6% of the normal subjects had comparably low counts. Finally, in over 5,000 other patients, the incidence of malignant disease was found to be about 10% in patients with total lymphocyte counts greater than 1,500 cells/cu mm, while in those patients having lymphocyte counts less than 1,000/cu mm, the incidence of malignancy was 28.9%.

An attempt to confirm the relationship between low lymphocyte counts and malignant neoplasms led to the initiation of the present study, using the records and patient population available at Mercy Hospital (Baltimore).

## Methods

The design of this study involved the designation of four groups of patients:

Group 1 included all of the patients with malignant neoplasms who were discharged or who expired at Mercy Hospital in the months of January and July 1971. Patients receiving therapy with steroids, immunosuppressive agents, or ionizing radiation were excluded from this group. There were 64 patients in this group.

Group 2 included 57 patients with benign neoplasms who were discharged or who expired at Mercy Hospital in the months of January and July 1971.

Group 3 comprised a series of 100 randomly selected differential counts done as a part of a routine preemployment evaluation at Mercy Hospital. This provided a supposedly normal, nonhospitalized control group.

Group 4 consisted of a randomly selected group of 67 patients aged 50 and above who were hospitalized at Mercy Hospital in January 1971. This provided an elderly nonmalignant, hospitalized control group. Patients with neoplasms or other known causes of lymphocytopenia were excluded from this group.

For purposes of this study, *absolute lymphocytopenia* was defined as a total circulating lymphocyte count of less than 1,000 cells/cu mm. *Relative lymphocytopenia* was defined as having fewer than 15% lymphocytes on peripheral smear.

All total and differential leukocyte counts were done in the hematology laboratories at Mercy Hospital. Total leukocyte counts were obtained with a Coulter electronic cell counter, and differential counts were made from Wright-stained peripheral smears.

## Results

The results of this study are summarized in Table 2. The average total lymphocyte count for each group is shown, and it can be seen that the malignant group had the lowest mean total lymphocyte count of the four groups. This difference is significant when groups 1 and 2, and groups 1 and 3 are compared (Student's T-test) but fails to reach statistical significance in a comparison between groups 1 and 4.

The malignant neoplasm group (Group 1) has a significantly higher percentage of patients with both relative and absolute lymphocytopenia. Differences between the three control groups on this variable were not significant ($x^2$ test), however the differences between the malignant neoplasm group and the other three groups were all highly significant.

Since many patients in this study had more than one differential count done during their hospitalization, it seemed pertinent to examine the differences between groups with respect to the total numbers of differential counts which are abnormally low. The last line of Table 2 shows this information, and it can be seen that there are significantly more such counts in the malignant group than in any of the control groups.

Figure 1 shows some of this data by means of a vertical bar graph. The differences between the malignant neoplasm group and the three control groups are perhaps more evident when presented in this fashion.

The mean ages of the patients in the four groups showed some differences, and it would be important to examine these differences in order to eliminate the possibility that age accounts for the observed variation in total lymphocyte counts. The mean ages of groups 2 and 3, the benign neoplasm group and the healthy normal group, were considerably less than the mean ages of groups 1 and 4. Coefficients of correlation (Spearman's rank-order correlation coefficient) were done in each group, and in no case was there any significant relationship between age and total lymphocyte counts.

**Table 2: Comparison of Study Groups**

(Numbers in parentheses are percentages. Group 1 = malignant neoplasms; Group 2 = benign neoplasms; Group 3 = healthy normals; Group 4 = elderly, nonmalignant, hospitalized controls.)

| | Group 1 | Group 2 | Group 3 | Group 4 |
|---|---|---|---|---|
| Total Number of Patients | 64 | 57 | 100 | 67 |
| Mean Age | 59.2 | 38.1 | 31.2 | 65.3 |
| Age Range | 8-85 | 1-77 | 16-63 | 50-95 |
| Total Number of White Counts Done | 169 | 73 | 100 | 107 |
| Average WBC | 10801 | 7519 | 6843 | 8578 |
| Average Total Lymphocyte Count | 1792 | 2101 | 2071 | 1922 |
| Number of Patients With At Least One | 22 | 6 | 6 | 8 |
| Total Lymph Count Less than 1000 | (34.4) | (10.5) | (6.0) | (11.9) |
| Number of Total Lymphocyte Counts | 34 | 6 | 6 | 11 |
| Less Than 1000 | (20.1) | (8.2) | (6.0) | (10.3) |
| Number of Patients With At Least One | 30 | 8 | 5 | 20 |
| Diff Showing Fewer Than 15% Lymphs | (46.9) | (14.0) | (5.0) | (29.9) |
| Number of Differential Counts With | 72 | 9 | 5 | 27 |
| Fewer Than 15% Lymphocytes | (42.6) | (12.3) | (5.0) | (25.2) |
| Number of Patients With BOTH Relative | 21 | 5 | 4 | 7 |
| and Absolute Lymphocytopenia | (32.8) | (8.7) | (4.0) | (10.4) |
| Number of Diffs With BOTH Relative | 31 | 5 | 4 | 9 |
| and Absolute Lymphocytopenia | (18.3) | (6.8) | (4.0) | (8.4) |

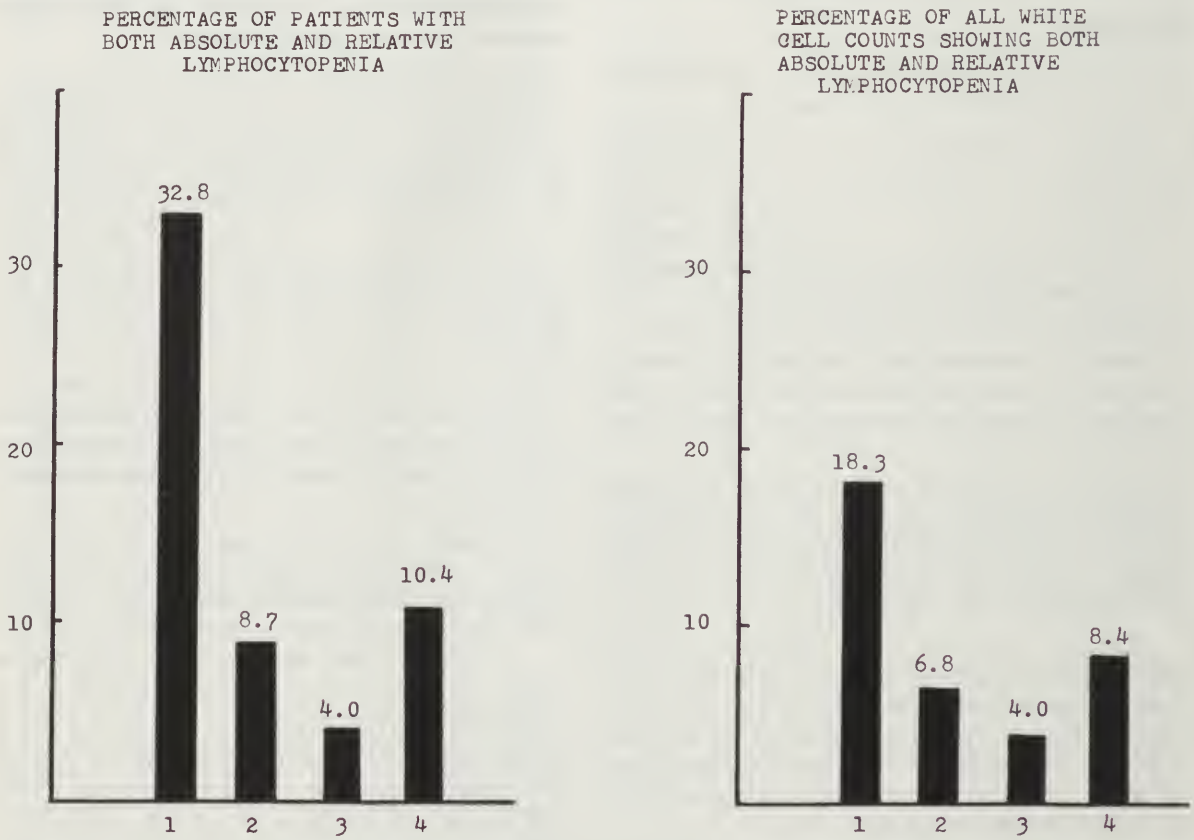



Figure 1: Graphic Presentation of Intergroup Differences. (Group 1 = malignant neoplasms; Group 2 = benign neoplasms; Group 3 = healthy normals; Group 4 = elderly, nonmalignant hospitalized patients.)

## Discussion

The results of this brief study point to a significant relationship between lymphocytopenia and malignancy, thus confirming the results obtained by others.[1-4] The etiology of this relationship however, is still unclear. It is a well recognized fact that the lymphocyte is involved in the mediation of cell-bound immunity.[5] It is also well known that patients with malignant diseases often demonstrate alterations in immunological reactivity.[3]

In patients who have been immunosuppressed, neoplastic disease has been documented at an incidence of 100 times greater than would be expected in the general population.[6] Patients with deficiencies of cell-bound immunity have been found to have a high incidence of malignancy; in animal studies, treatment with antilymphocyte serum, radiation, or neonatal thymectomy, has been shown to increase the frequency of development of neoplastic disease.

There is a good deal of evidence for the view that multiple unrecognized neoplastic events occur continuously throughout life, with the lymphocyte being part of an immunologic surveillance mechanism which serves to eliminate incipient neoplastic cells.[7] Sensitized lymphocytes from patients with malignancies have been found to have the ability to destroy malignant cells,[7-9] and lymphocyte immunotherapy has been used, with varying degrees of success, in the treatment of malignant neoplasms.[7,8,10] In addition, active immunization with BCG or autologous tumor cells can induce a heightened immune response against tumor antigens.[10]

It has been speculated that perhaps in the living organism, the lymphocyte acts as a protective mechanism, and the loss of this protection opens the door to dormant causative agents which then initiate a neoplastic lesion.[11] Much further work remains to be done in this area.

Since in at least two previous studies[1,4] approximately 20% of the patients with total lymphocyte counts below 1,000/cu mm have been found to have malignant tumors, and since this study has shown a significant relationship between malignant neoplasms and lymphocytopenia, it might be considered advisable for hematology laboratories to routinely report the total lymphocyte count on laboratory slips. Repeated unexplained low lymphocyte counts might then be considered an indication for further study to rule out any possible malignant process.

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* * *

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NEIL SOLOMON, MD, PhD, Secretary

Maryland State department of health and mental hygiene

# AN OVERVIEW OF TUBERCULOSIS IN MARYLAND

STERLING BENTLEY
Chief, Division of Respiratory Diseases
Department of Health and Mental Hygiene
Baltimore

Tuberculosis services in Maryland are delivered through the coordinated effort of many diversified groups and with public cooperation. Major groups involved in providing these services are the Division of Respiratory Diseases, Maryland State Department of Health and Mental Hygiene, which provides direction, consultation, and coordination of statewide activities; Mount Wilson State Hospital, which provides inpatient hospital care for tuberculosis sufferers; 24 local health departments, which provide outpatient care for patients and their families; the state laboratory, which provides excellent services; and the Maryland Tuberculosis and Respiratory Disease Association and its affiliates.

Last, but very important, is the person on the firing line — the private physician in the community. In many instances the individual with tuberculosis first sees the physician of his choice, who may either diagnose, treat, and report the case, or call on the local health department to provide care for the patient, family and contacts. It is from this beginning point that all treatment, epidemiological, and preventive activities originate.

## Reported Cases For 1971

Private physicians and other sources reported 840 new active cases to local health departments in 1971 as compared to 942 in 1970 — a reduction of 10.8%. There were also 117 reactivations or treatment failures reported. More than 6,000 contacts of these new and reactivated cases required examinations and preventive treatment.

## Tuberculosis Trends

That tuberculosis is on the decline is a known fact to physicians in every part of the state. Although considerable progress has been made in reducing incidence and deaths due to this disease, tuberculosis is still a serious health problem. There are, however, several bright spots in the picture. In 1962 there were 226 deaths due to tuberculosis, and by 1971 this number had been reduced to 121 — a 46.5% decrease. Table 1 shows a similar decrease in the case rate.

**Table 1: Tuberculosis Cases and Case Rates* 1962 — 1971**

| Year | | United States | Maryland | Baltimore City | All Md. Counties |
|---|---|---|---|---|---|
| 1962 | cases | 53,315 | 1385 | 780 | 605 |
| | rates | 28.7 | 42.5 | 83.7 | 26.1 |
| 1967 | | 45,647 | 1187 | 683 | 504 |
| | | 23.1 | 32.2 | 74.8 | 18.1 |
| 1968 | | 42,623 | 1094 | 622 | 472 |
| | | 21.3 | 29.0 | 67.7 | 16.5 |
| 1969 | | 39,120 | 912 | 500 | 412 |
| | | 19.4 | 23.8 | 55.7 | 14.1 |
| 1970 | | 37,187 | 942 | 493 | 449 |
| | | 18.3 | 24.0 | 54.4 | 14.9 |
| 1971 | | 35,035 | 840 | 458 | 382 |
| | | 17.0 | 20.9 | 50.8 | 12.3 |

* rates per 100,000 population

Another measure of progress is inpatient hospital treatment for the disease. In 1969, 185,588 hospital patient days were required for tuberculosis treatment, while in 1971, only 106,690 days were needed. During this same period the average length of hospital stay for tuberculosis pa-

tients was reduced from 161 days to 101 days; however, the daily cost per patient increased from $21.00 to over $35.00. The rapid reduction in total hospital patient days required for tuberculosis care and the shorter hospital stay clearly demonstrate that the major responsibility for tuberculosis has shifted from inhospital care to outpatient care in the community.

Primary tuberculosis has also shown a rather remarkable decrease in the past several years. In 1962, the state reported 130 cases of primary disease and for 1971 only 48 cases were reported — a 63% reduction.

Pulmonary disease in 1971 accounted for 94% of the new cases. The extent of the disease on initial diagnosis was 17% minimal, 34% moderately advanced, and 29% for advanced — nearly the same as in 1962. This indicates that there has been no significant improvement in finding cases early, and is strong evidence for the need to greatly expand preventive activities. Table 2 presents a breakdown of the new cases for 1971.

**Table 2: Newly Developed Active Cases**

| Form & Extent of Disease | Not Previously Reported (new active cases) | Previously Reported Active (reactivated cases) |
|---|---|---|
| Total | 840 | 117 |
| Pulmonary Total | 786 | 114 |
| Primary | 48 | — |
| Minimal | 210 | 25 |
| Moderately Advanced | 265 | 33 |
| Far Advanced | 227 | 56 |
| Extent Not Specified | 2 | — |
| Tuberculous Pleurisy with Effusion | 34 | — |
| Extrapulmonary | 54 | 3 |

Age, race, and sex continue to be important epidemiological factors in identifying high risk sub-population groups where services need to be redirected.

**Table 3: Newly Developed Cases by Age and Sex**

| Age | Total | New Active Cases | | | | Reactivated Cases |
|---|---|---|---|---|---|---|
| | | White | | Other | | |
| | | Male | Female | Male | Female | |
| Total | 840 | 279 | 127 | 291 | 143 | 117 |
| Under 5 yrs. | 23 | 6 | 5 | 6 | 6 | — |
| 5 - 14 yrs. | 12 | 1 | 5 | 3 | 3 | — |
| 15 - 24 yrs. | 82 | 19 | 12 | 27 | 24 | 3 |
| 25 - 44 yrs. | 244 | 66 | 30 | 93 | 55 | 16 |
| 45 - 64 yrs. | 310 | 114 | 46 | 115 | 35 | 57 |
| 65 & over | 169 | 73 | 29 | 47 | 20 | 41 |

Table 3 illustrates that a significant portion of the tuberculosis problem is in persons over 45 years of age, especially males. The age group over 45, which comprised only 28% of the total population, accounted for 57% of the new cases in 1971.

Where are the cases of tuberculosis coming from? Today, most new cases in Maryland and elsewhere in the country are a result of endogenous breakdown of individuals already infected. Most of these individuals were infected years ago, and it is estimated that more than 85% of the new cases each year come from this group. New infections — the result of recent exposure to an infectious case — account for less than 15% of the new cases.

## Geographic Distribution

Of the 24 political subdivisions in the state, Baltimore City continues to report the largest number of cases each year, and it is in Baltimore City where the highest case rates per 100,000 population are to be found. Several counties on the Eastern Shore are also heavily seeded with tuberculosis and have case rates significantly higher than the state average.

## Tuberculosis Prevalence

The most accurate measure of tuberculosis prevalence in Maryland is the case registers in the local health departments. On December 31, 1971, there were 8,237 diagnosed cases on local tuberculosis registers — 704 with active disease and 7,533 classified as quiescent or inactive. All of these cases required tuberculosis services with 3,906 on drug therapy. Of the total cases on registers at the end of the year, only 262 were hospitalized for the disease. Most of these were in Mount Wilson State Hospital, the only state-operated tuberculosis facility for Maryland residents.

## Tuberculosis Infection

Most of the estimated 500,000 Marylanders infected with the tuberculosis organism are older persons, and many of the new active cases of tuberculosis come from this portion of the population. Tuberculin testing programs carried out in many parts of the state indicate that the reactor rate for adult residents is between 15% and 25% with the highest rates in persons over 45 years of age. Analysis of results for over 120,000 first graders and young adolescents tested during the past three years shows that the reactor rate in Maryland school children is less than 0.2% for first graders and approximately 1.0% for young adolescents. This indicates that unless a child has been in close contact with an infectious case of tuberculosis, he is not likely to ever become infected with the tubercle bacillus.

## Prevention of Tuberculosis

Within the past few years it has been clearly demonstrated that tuberculous disease and infection can be prevented when isoniazid-prophylaxis is used. The Public Health Service has reported that one year of isoniazid-prophylaxis can reduce future morbidity from tuberculosis by as much as 85%.

Private physicians, industries, nursing homes, general hospitals, and local health departments placed more than 10,000 persons on preventive treatment during 1971. Most of these persons were high risk contacts, converters, skin test positive persons who have had incomplete or inadequate treatment for tuberculosis and who became inactive less than five years ago, and positive skin test persons who have never been treated but whose X-rays indicate they had disease sometime in the past.

In summary, the epidemiological picture for tuberculosis in Maryland shows a declining incidence of the diease, with most new cases occurring in older and poor persons, as a result of endogenous breakdown of old infections. Transmission of the organism is very low in young children. Information indicates that traditional case-finding methods are not successful, that preventive treatment needs to be expanded, and that outpatient programs need assistance to handle the major responsibility for treating tuberculosis. The picture also shows that despite considerable progress, tuberculosis remains a serious and expensive health problem in Maryland.


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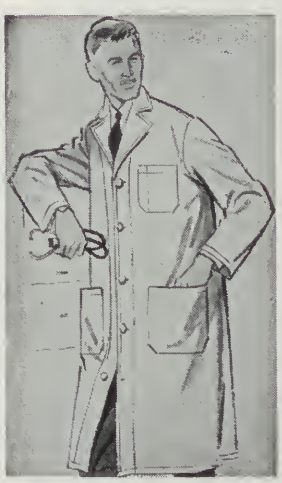
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# MEMBERSHIP, NUMBER ONE MMPAC GOAL

James H. Sammons, MD, former chairman of the AMPAC Board of Directors, and now a member of the AMA Board of Trustees as well as immediate past president of the Texas Medical Association, recently made the following statement to a group of San Antonio physicians. "If the welfare of our patients continues to be based on political judgments, then we will have to get into the political arena where the decisions are being made." He urged physicians throughout the state "to become extremely active" in political action committees of their county, state, and national associations.

Membership must always be the top priority of any volunteer organization. We urge every physician to consider seriously his obligation not only to himself, but to medicine as a whole. Membership in PAC is by far the most effective means available for the individual to participate in the election of honorable and fair-minded individuals to the Congress.

MMPAC is a voluntary, nonprofit organization composed of physicians and their wives. It devotes its efforts to the election of legislators to the Congress who will be fair-minded and honorable in their consideration of health legislation. Further, to help members of the medical profession to assume a more active and effective role in public affairs MMPAC attempts to help them better understand political issues.

MMPAC is not affiliated with any political party. Rather, MMPAC carefully considers the program and past record of each individual candidate to determine which ones to support.

MMPAC is independent of the Medical and Chirurgical Faculty of Maryland.

There are many avenues available to help support the candidates of our choice. Voter registration drives, absentee ballot campaigns, candidate support committees, television candidate support, evaluation of the effectiveness of an individual's campaign, and the familiar entertaining for the candidate at coffees, picnics, teas, etc are all means which are used by MMPAC to supplement monetary contributions.

As pointed out before in this space, once a Congressman is elected MMPAC maintains close contact with him. This close contact provides for a continuing exchange of views which is beneficial to both.

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### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
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1. Title of exhibit: .....

.....

2. Please attach a 50-100 word description of the exhibit: .....

3. Give amount of space required, depth, width, and height: .....

If exhibit has side panels, are depth and width included above? .....

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4. Electrical or other requirements: .....

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5. Has exhibit been shown at other medical meetings? .....

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6. Name and title of exhibitor: .....

.....

7. Name of Institution cooperating in the exhibit: .....

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8. Address of exhibitor: .....

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### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 500 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
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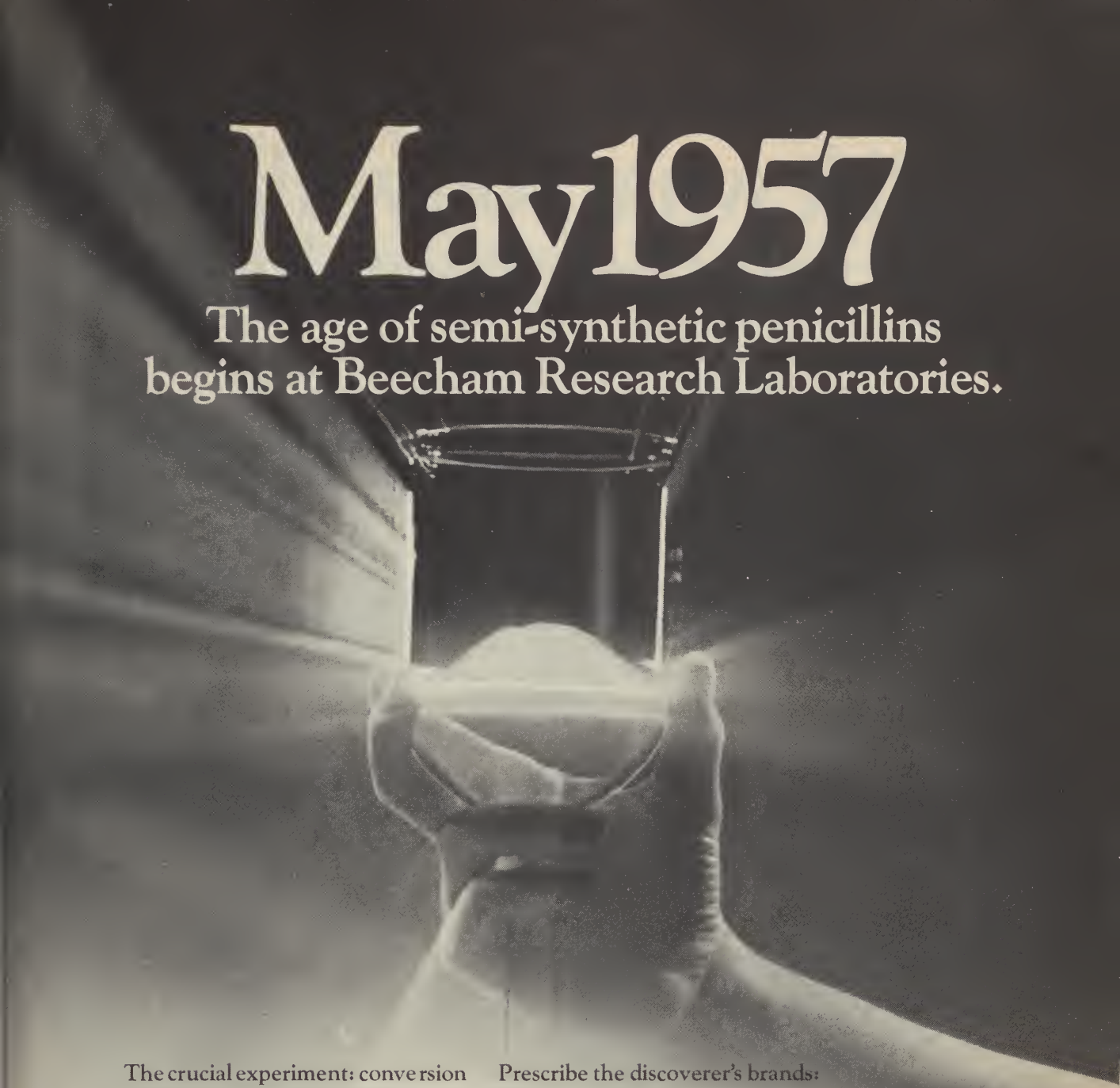
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## Before

3/29/67 Before therapy with 5%-FU cream. Patient P. T. shows a moderately severe solar keratotic involvement. Note residual scarring from the previous cryosurgical and electrosurgical procedures on forehead and ridge of nose adjacent to periauricular area.

## After

6/12/67 Seven weeks after cessation of therapy. Reactions have subsided. Residual scarring is not seen except for that due to prior surgery. Inflammation has disappeared and face is clear of keratotic lesions.



# The lesions on his face may be solar/actinic — so-called "senile" keratoses...and they may be premalignant.

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These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



*Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.*

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emergency medical services

# Better Staffing—Hospital Emergency Departments

A. I. DOKTORSKY, MD
Member, American
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Pressures being placed upon emergency rooms of today's hospitals by the community have greatly increased their patient load. As a result, hospitals are making every attempt to upgrade the staffing of their facilities to best serve this increased outpatient demand quickly and professionally.

Methods for staffing emergency room are numerous. The success of any of the following suggested methods, however, depends upon mutual agreement and understanding between doctors and personnel of the emergency room and the hospital medical staff.

**House Staff**

The first method of hospital emergency room staffing involves the use of inhospital personnel with proper supervision by a staff doctor. Rotating with other responsible physicians, each doctor is on call for a 24-hour period. He is required to stay in the hospital for his entire tour of duty.

**Rotating Panels**

Another staffing procedure involves a cooperating group of the medical staff headed by a surgeon or other responsible physician. This "team" is assigned to cover the emergency room for three- to five-week periods.

**Contracting Groups**

A group of doctors, nonhospital staff members, agree to cover the emergency room service for pay from the hospital. They handle all emergency room cases, referring patients to the regular medical staff only if hospitalization is required.

**Staff Physicians**

This staffing procedure works much like the first. It involves the manning of the emergency room by staff doctors who agree to cover the room for a set fee. Again, they refer all patients requiring extended hospitalization to the medical staff's appropriate department.

**The Corporation.**

Recently, some doctors have united to form a corporation providing for the care of patients both in the hospital emergency room and through associate clinics away from the hospital. Doctor-members of the corporation serve a tour of duty in the emergency room being responsible for all of its eventualities. As in other staffing procedures, they refer those patients requiring additional treatment in the hospital to the established medical staff.

In addition to assuming responsibilities of the emergency room, members of the corporation refer nonemergency patients who seek help at the hospital facility, to an outpatient clinic which is also staffed by corporation members.

Because both emergency room care and outpatient clinic referral are handled by the same group of doctors and staff, administrative functions are combined. Bookkeeping and auditing is up apart from but performed within hospital procedure.

At the end of the year, all proceeds coming from their services are divided by the members of the participating staff. Each one's share is based on the number of points accumulated by hours worked in the emergency room. Other means of equitable sharing of the profits might be found but must be agreed upon by all members of the corporation. A definite contract should be drawn up between the hospital and the participating physicians.

The continued and increasing use of the emergency room by the general public provides a

good opportunity for its use as a teaching area for interns, residents, and other medical personnel. An important consideration in evaluating the residency program of a hospital is the availability of experience the resident receives in ambulatory patient care. (This experience should occupy at least 25% of the resident's time and should run concurrently with the inpatient service.)

Those doctors who enter family practice may further gain from extended experience in the hospital emergency room. The family physician is responsible for the total health care of a patient. He takes care of a patient's need within one or more fields of medicine and refers the patient to a specialist's care should his needs warrant it.

The family physician helps develop a continuity in the health care of a patient. Through his work in the emergency room, the resident family physician may lend the initial treatment to a patient and follow through to inhospital care if the patient's condition is serious enough to require his staying in the hospital. Also, if the patient is well enough to be sent home but has to have further treatment in a clinic, the family physician may continue to see the patient away from the hospital.

As demands continue to be made on hospital emergency rooms, it will be necessary to find the most expedient way of filling the needs of patients seeking emergency care. Many alternate methods appear to be workable. One must be selected on the basis of community needs, and mutual agreement between the hospital and the emergency staff. Such considerations as funds, fees, time, and responsibility-sharing should be agreed upon and create the basis for a contract between participants.

Through cooperation between hospital emergency staff, and the community itself, the growing needs of the people will be met in this specific health service.


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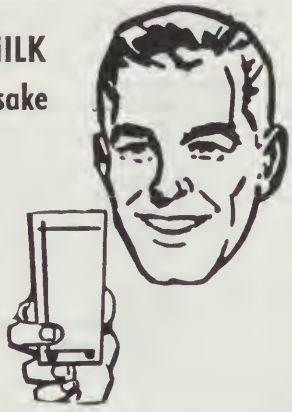
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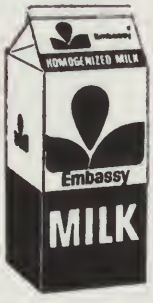
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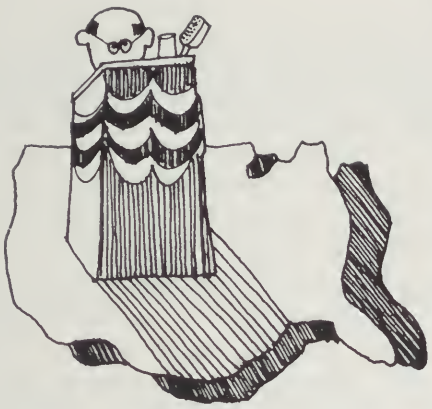
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# Advertisers in This Issue


A & F Nurses Registry ..... 12

AMA Membership ..... 5

AMA Medicredit ..... 89

Arch Laboratories ..... 16

Arundel Fed. Savings & Loan Assoc. ..... 88

Baltimore Nurses Exchange ..... 87

Beecham-Massengill Pharm. ..... 83

Gaylord Brooks & Co. ..... 73

Burroughs Welcome Co. ..... 63

Capital Savings & Loan Association ..... 87

Oscar Caplan & Sons ..... 22

Caribe-Marine ..... 12

Donatelli, Rudoph & Schoen ..... 16

Embassy Dairy ..... 88

Franklin Uniform Co. ..... 76

Geigy Pharmaceuticals ..... 1

James A. Griffin ..... 80

Herget & Co., Inc. ..... 82

Ives Laboratories, Inc. ..... 78

Eli Lilly & Co., Inc. ..... 46

Manekin Corporation ..... 25

Monarch Lincoln Mercury ..... 81

Pharmaceutical Mfrs. Assoc. ..... 43-45

Wm. P. Poythress Co., Inc. ..... 93

T. Rowe Price ..... 82

Public Service Vehicle Equipment Leasing 32

Read's Drug Stores ..... 22

A. H. Robins ..... 41-42

Roche Laboratories ..... Cover 4, 8-9, 28-29, 84-85

Sakura Palace ..... 88

Manual Schwartz Hearing Rehabilitation .. 87

G. D. Searle Co. ..... 64-65

Security Business Services, Inc. ..... 25

Special Diet Shop ..... 87

Sterling Lighting Co. ..... 87

Stuart Pharmaceuticals ..... 6-7, 66

Therapeutic Appliances ..... 22

Tio Pepe Restaurant ..... 88

Towson Surgical Supply ..... 82

Towson Valley Motors ..... Cover 3

Upjohn Co. ..... 94-96

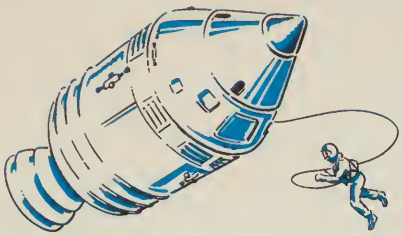
D. Stuart Webb Advertising Services, Inc. .. 18

White Rice Inn ..... 82

Winthrop Laboratories ..... 2-4

Vera Woods Personnel Service ..... 21

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**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

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infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

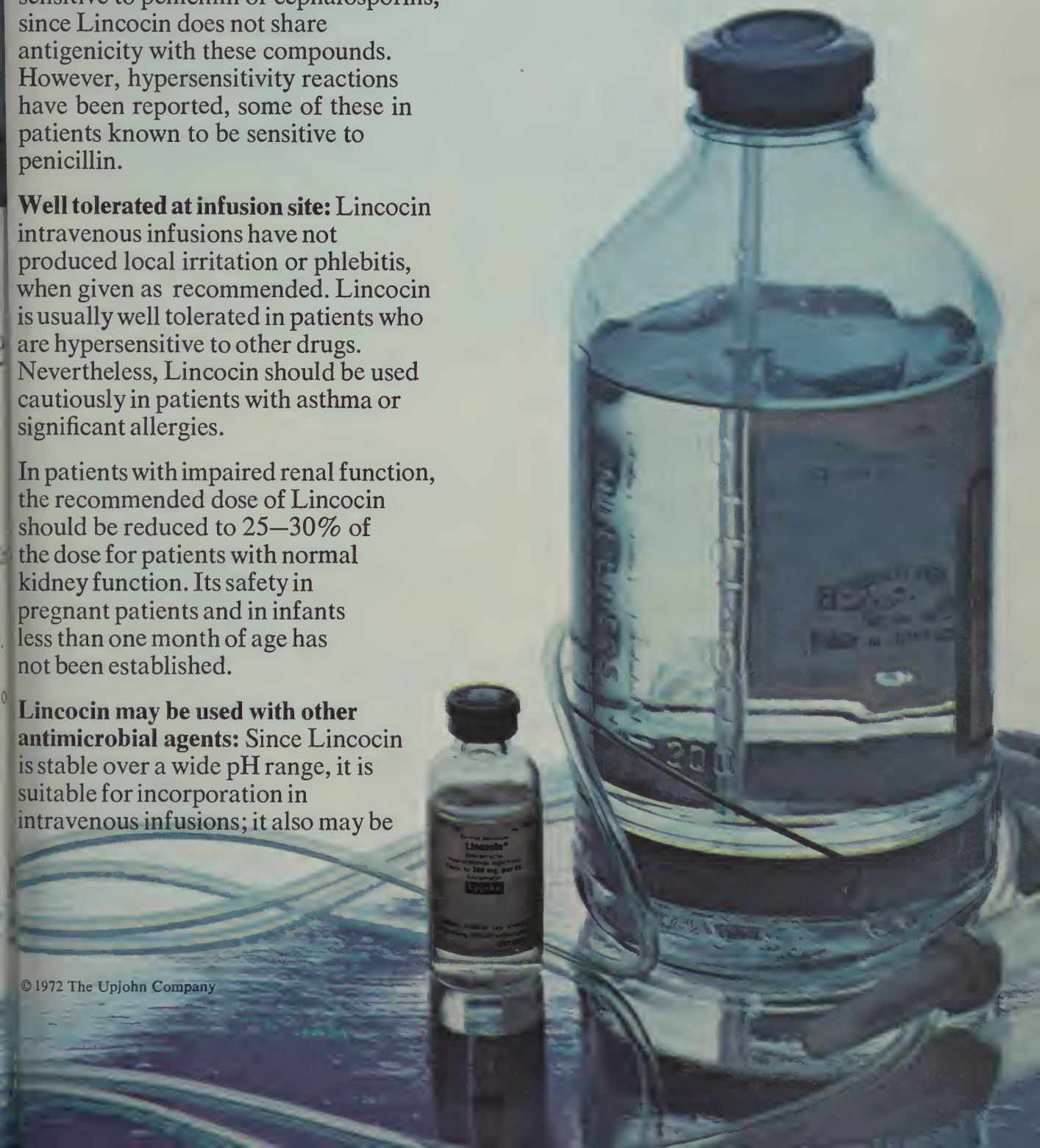
**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

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Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of $\beta$-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

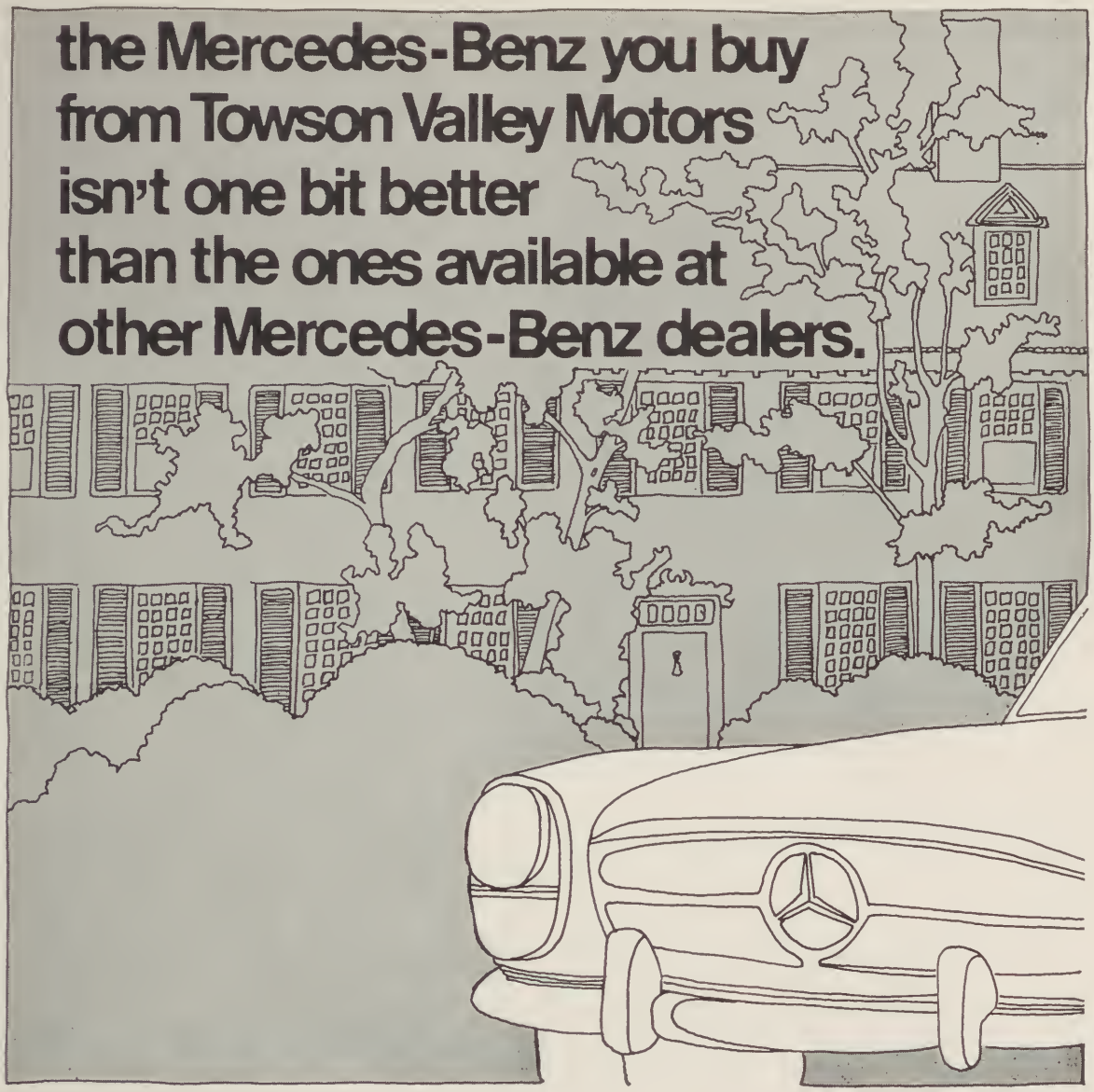
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For moderate states of psychic tension, 5-mg or 2-mg Valium tablets *b.i.d.* to *q.i.d.* can usually provide reliable relief. For severe tension/anxiety states, the 10-mg tablets often produce desired results.

The most commonly reported side effects are drowsiness, ataxia and fatigue. Until individual response is determined, caution patient against driving or operating dangerous machinery.

## Valium® (diazepam)

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**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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AUG 24 1973
SEP 4 1973

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VOLUME 21 OCTOBER 1972 NUMBER 10

## ARTICLES:

**An Introduction to Changing Times**—Edward F. Cotter, MD ..... 43

**Health Care Delivery Systems: What's Here, What's Coming**—John B. De Hoff, MD ..... 44

**Baltimore Hospital-Based Group Practice**—Joseph A. Mead, Jr., MD ..... 48

**Health Care Crisis—Role of Academic Medical Center**—John H. Moxley III, MD ..... 50

**Third-Party Payor Activities in Baltimore HMOs**
Hume O. Annan ..... 54

**Medical Practice and Practitioners in Eighteenth Century Maryand**—Douglas Carroll, MD ..... 57

**Peripheral Neuropathy Secondary to Isoniazid-Induced Pyridoxine Deficiency**—John F. Aita, MD; Thomas R. Calame ..... 68

## DEPARTMENTS:

**Maryland Medical Political Action Committee** ..... 10

**Your Medical Faculty at Work**—John Sargeant ..... 14

**Maryland State Department of Health and Mental Hygiene—Maryland HMOs at the Crossroads**—James C. Eshelman ..... 34

**Woman's Auxiliary—Doctor, Here's What Your Auxiliary Does** ..... 37

**Heart Page—Treatment of Cardiogenic Shock II**—Lawrence S. Cohen, MD .... 71

**Library—Nineteenth Century Medicine in America; New Accessions** ..... 74

**Rehabilitation Medicine—The Acutely Injured Hand and Rehabilitation**—Chris P. Tountas, MD ..... 86

**Alcoholism Section—Alcohol-Related Illnesses—Part III** ..... 94

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## MISCELLANY:

Doctors In the News 11
Hospital Salute 17
New Council Members 18
Medical News Briefs 19
Director's Newsletter 23
Sports Seminar 27
Open Forum 30
Book Reviews 36
Doctors Take Note 85
Annual Meeting 92
Scientific Exhibits 93
Classified Ads 99
Advertising Index 100



# rheumatoid arthritic blowup...

## Tandearil® Geigy

oxyphenbutazone NF

tablets of 100 mg.

*portant Note:* This drug is not a simple analgesic. not administer casually. Carefully evaluate patients ore starting treatment and keep them under close ervision. Obtain a detailed history, and complete sical and laboratory examination (complete nogram, urinalysis, etc.) before prescribing and at quent intervals thereafter. Carefully select patients, lding those responsive to routine measures, con- ndicated patients or those who cannot be observed quently. Warn patients not to exceed recommended age. Short-term relief of severe symptoms with smallest possible dosage is the goal of therapy. iage should be taken with meals or a full glass of k. Patients should discontinue the drug and report nediately any sign of: fever, sore throat, oral ons (symptoms of blood dyscrasia); dyspepsia, gastric pain, symptoms of anemia, black or tarry ols or other evidence of intestinal ulceration or norrhage, skin reactions, significant weight gain or ma. A one-week trial period is adequate. Discon- ue in the absence of a favorable response. Restrict tment periods to one week in patients over sixty. *ications:* Acute gouty arthritis, rheumatoid arthritis, umatoid spondylitis.

*traindications:* Children 14 years or less; senile ients; history or symptoms of G.I. inflammation or eration including severe, recurrent or persistent pepsia; history or presence of drug allergy; blood crasias; renal, hepatic or cardiac dysfunction; ertension; thyroid disease; systemic edema; matitis and salivary gland enlargement due to the g; polymyalgia rheumatica and temporal arteritis; ients receiving other potent chemotherapeutic nts, or long-term anticoagulant therapy.

*nings:* Age, weight, dosage, duration of therapy, stence of concomitant diseases, and concurrent ant chemotherapy affect incidence of toxic reac- s. Carefully instruct and observe the individual ent, especially the aging (forty years and over) have increased susceptibility to the toxicity of the g. Use lowest effective dosage. Weigh initially redictable benefits against potential risk of severe, n fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

*Precautions:* The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

*Adverse Reactions:* This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B) 98-146-800-E

*For complete details, including dosage, please see full prescribing information.*

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TA-8356-9



# a new outlook in chronic pain

## of moderate to severe intensity

Though Talwin® Tablets, brand of pentazocine (as hydrochloride), can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. Patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with meperidine or codeine. And that, in the long run, can mean a better outlook for your chronic-pain patient.

**Talwin Tablets are:**

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

**Talwin®**

brand of **pentazocine** (as hydrochloride)

the long-range analgesic

# a new outlook in chronic pain

## of moderate to severe intensity



**Contraindications:** Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

**Warnings:** *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

*Usage in Pregnancy.* Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

*Drug Dependence.* There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

*Acute CNS Manifestations.* Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

*Usage in Children.* Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Ambulatory Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

*Impaired Renal or Hepatic Function.* Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

*Myocardial Infarction.* As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

*Biliary Surgery.* Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

*Patients Receiving Narcotics.* Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

*CNS Effect.* Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

*Children Under 12 Years of Age.* Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

*Duration of Therapy.* Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

*Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1583)

**50 mg. Tablets**

# Talwin®

brand of **pentazocine** (as hydrochloride)

**the long-range analgesic**



# if skin is infected, or open to infection...

# choose the topical that gives your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

## Special Petrolatum Base

## Neosporin® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical aftercare, and pyogenic dermatoses.

*Precaution:* As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

*Contraindications:* Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

Wellcome

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Research Triangle Park
North Carolina 27709


When irritable colon feels like this

# ...in the presence of spasm or hypermotility, gas distention and discomfort, **KINESED®** provides more complete relief:

- ☐ belladonna alkaloids—for the hyperactive bowel
- ☐ simethicone—for accompanying distention and pain due to gas
- ☐ phenobarbital—for associated anxiety and tension

**Contraindications:** Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

**Precautions:** Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

**Side effects:** Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

**Dosage:** *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

*Children 2 to 12 years:* One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

**STUART PHARMACEUTICALS** | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109

(from the Greek **kinetikos**,
to move,
and the Latin **sedatus**,
to calm)

# KINESED®

antispasmodic/sedative/antiflatulent

Each *chewable tablet* contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.

Chuckwalla (*Sauromalus obesus*):
This southwestern desert lizard seeks
shelter in crevices of rocks.
When attempts are made to probe him
from his niche, he gulps air
until his torso is distended up to
sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

# Valium®
# (diazepam)

## To help you manage excessive psychic tension

Maryland Medical Political Action Committee

**RAYMOND L. MARKLEY, MD, Chairman**

**MRS. FRANCIS C. MAYLE, Editor**

# ELECTION REMINDERS

Election Day is only a few weeks away. While many of you may have already decided how you will cast your vote, there may be others who are still uncertain. Therefore, this month we will devote this column to a brief exposition of the records of Maryland's incumbent Congressmen. Obviously, the challengers cannot have a voting record since they have not held the office. However, a better understanding of the records may help you make a more valid comparison.

Listed below you will find the following information for each incumbent Congressman: whether or not he is a sponsor of the AMA's Medicredit health proposal; his favorable percentage rating by these three organizations—the Americans for Constitutional Action (ACA), the Americans for Democratic Action (ADA), and the Committee for Political Education of the AFL-CIO (COPE). The only committee memberships mentioned will be those having a direct influence on health legislation.

The Fourth District will not be listed because it is a newly structured district and has no incumbent Congressman. The Republican candidate for that office is Mrs. Marjorie Holt and the Democratic candidate is Mr. Werner Fornos. Both candidates have expressed their views with regard to health legislation during the course of the campaign.

In the First District the incumbent is William Mills, a Republican. Representative Mills has an ACA rating of 95%, an ADA rating of 3%, and a COPE rating of 11%. While Congressman Mills is not a sponsor of Medicredit as of this writing, he has voted with medicine on every bill to come before Congress since his election. The Democratic candidate is State Delegate John R. Hargreaves.

In the Second District the incumbent is Clarence Long, a Democrat. Representative Long has an ACA rating of 17%, an ADA rating of 70%, and a COPE rating of 86%. He is not a sponsor of Medicredit and is a member of the Appropriations Committee. The Republican candidate is State Senator John J. Bishop.

The incumbent in the Third District is Paul Sarbanes, a Democrat. The Congressman has an ACA rating of 17%, an ADA rating of 81%, and a COPE rating of 82%. He is not a sponsor of Medicredit. The Republican candidate is Robert D. Morrow.

In the Fifth District the incumbent is Larry Hogan, a Republican. Mr. Hogan has an ACA rating of 63%, an ADA rating of 19%, and a COPE rating of 35%. He is a sponsor of Medicredit and holds views very favorable to medicine. The Democratic candidate is State Senator Edward T. Conroy.

The Sixth District incumbent is Goodloe Byron, a Democrat. Congressman Byron has an ACA rating of 69%, an ADA rating of 19%, and a COPE rating of 50%. He is a sponsor of Medicredit and is very favorably disposed towards medicine. He is a member of the Full Committee on Health and the Interstate and Foreign Commerce Committee. The Republican candidate is State Senator Edward J. Mason.

The Seventh District incumbent is Parren Mitchell, a Democrat. His ACA rating is 11%, his ADA rating is 100%, and his COPE rating is 82%. The Congressman is not a sponsor of Medicredit. The Republican candidate is Verdell Adair.

In the Eighth District the incumbent Congressman is Gilbert Gude, a Republican. Mr. Gude has an ACA rating of 27%, an ADA rating of 89%, and a COPE rating of 77%. He is not a sponsor of Medicredit. Representative Gude is interested in malpractice legislation and has introduced a bill dealing with this problem (applicable to the District of Columbia only). As it is now written the legislation has problems which remain to be ironed out. The Democratic candidate is Joseph G. Anastasi.

One last word . . . . Go to the polls and cast your vote! The citizen who fails to vote cripples democratic government at its very heart.

# Doctors in the News

**J. Brett Lazar,** MD, Carroll County health officer, has been certified by the American Board of Preventive Medicine as a specialist in Public Health.

•

**Alfonso H. Janoski,** MD, assistant professor of medicine at the University of Maryland School of Medicine, has received a three-year grant for $88,000 from the National Institute of Arthritis and Metabolic Diseases to pursue research on the role of adrenal steroids in salt loss.

•

**Lin-Tsun Chen,** PhD, a special fellow at the Johns Hopkins University School of Medicine, is among a group of 28 skilled and scientific investigators receiving grants from the Leukemia Society of America. Their goal: find a way to control or cure leukemia and allied illnesses such as the lymphomas and Hodgkin's disease.

•

The new associate director of the Maryland Psychiatric Research Center in Catonsville is **T. Glyne Williams,** MD. Dr. Williams, superintendent of Rosewood State Hospital since 1969, replaces **Charles Savage,** MD, now chief of psychiatric service of the drug treatment center of the VA Hospital in Baltimore.

•

**Arthur L. Haskins,** MD, professor of obstetrics and gynecology at the University of Maryland School of Medicine, authored a major article entitled "Early Recognition of Prenatal Disorders" that appeared in a recent issue of *Modern Medicine,* a national medical journal.

•

**J. O'Neal Humphries,** MD, has been elected president of the Central Maryland Heart Association for 1972-1973. He succeeds **Kenneth B. Lewis,** MD. Dr. Humphries is associate professor of medicine at the Johns Hopkins University School of Medicine.

The current slate of officers also includes **Gustav C. Voigt,** MD, as president-elect and **Henry H. Kwah,** MD, as vice president.

•

Recent appointments at Baltimore's Provident Hospital include:

**Fitzpatrick Wilson,** MD, as chief of obstetrics and gynecology. Dr. Wilson comes to Baltimore from Washington where he was associated with Freedman's Hospital and Howard University.

**Ernest Austin,** MD, as chief of surgery. He was formerly director of surgery at Reynolds Memorial Hospital in Winston-Salem, NC.

**Lionel Rose,** MD, as director of the Sickle Cell Center. Dr. Rose had served as medical director of the Provident Comprehensive Health Center.

**Andre Riguad,** MD, to full-time associate pathologist. Before joining Provident, Dr. Rigaud was a pathologist at Clinton Community Hospital in Prince George's County.

•

The following members of the Maryland Academy of Family Physicians, all MDs, were made Fellows of the American Academy of Family Physicians at the recent meeting of the American Academy in New York.

**Thomas Gilbert Abbott, Aris T. Allen, Faye Watson Allen, Max Baum, Earl Miller Beardsley, Melvin N. Borden, John R. Buell, Joseph Hess Caricofe, John Thomas Chissell, Archie Robert Cohen, Charles Paul Crimy, Luis Miguel Cuza, John P. D'Angelo, Edward E. Ditto III, Joseph C. Eshelman, Charles Farwell, James Frenkil, Marion Friedman, Julius Gluck, Abram Goldman, William David Gray.**

Also, **Eugene James Guazzo, Joseph Roy Guyther, George J. Hageage, Philip Walter Heuman, Benjamin Highstein, Carl Jorgen Housmann, Willard P. Hudson, Klaus H. Huebner, John Charles Hyle, Frederick M. Johnson, Philip Edward Jones, Lauriston L. Keown, Harry Lester Knipp, Lester H. Kolman, Edward J. Kowaleski, Keaciel K. Krulevitz, Edwin Charles Lane, William T. Layman, C. Rodney Layton, Snyder Leventhal, Leon R. Levitsky, Leo H. Ley Jr., John Richard Lilly, Naomi Therese Lucius, Thomas F. Lusby II, Robert F. Manuzak, Lawrence Maryanov, Robert Sadler McCeney, J. Nelson McKay, Philip W. Mercer.**

Also, **Leslie R. Miles, Andrew C. Mitchell, Irwin Harold Moss, C. Herbert Mueller, Joseph R. Myerowitz, Nathan E. Needle, Charles F. O'Donnell, William R. O'Rourke, George H. Patrick, William H. Patrick, Morris Perry, Sarah M. Peyton, Malcolm D. Phillips, Bennet A. Porter Jr., Louis Pratt.**

Also, **Charles J. Savarese, John F. Schaefer, Milton Schlenoff, Eugene Schnitzer, Aaron Charles Sollod, Joseph Taler, Peter V. Thorpe, John B. Umhau, Hugh Walter Ward, Howard N. Weeks, Daniel Irvin Welliver, Milton D. Westberg, and Charles H. Winnacott.**

Med-Chi salutes all of you!

**Theodore T. Niznik,** MD, chief of the department of nuclear medicine and president of the medical staff at Baltimore's North Charles General Hospital, has passed the pilot examination in the broad field of nuclear medicine given by the American Board of Nuclear Medicine.

Dr. Niznik is among the first in his field to be certified as a specialist in all aspects of the diagnostic, therapeutic, and medical research uses of radioactive materials.

•

Seven Marylanders are among a group of 179 physicians recently admitted to membership in the American College of Physicians.

Baltimore doctors include: **Lawrence Awalt, Young Chun, Vilis E. Kilpe, Daniel Lindenstruth, Joseph H. Miller,** and **John H. Mulholland.**

Also included is **Earl Campbell** of Cumberland.

•

By way of the ASA Newsletter we learn that **Robert F. Beller,** MD, and **Cyrus Vesuna,** MD, both of Potomac, Md, have been certified as Diplomates of the American Board of Anesthesiology; also **Letica C. Quetulio-del Pilar** of Baltimore.



**Dr. Donner**

The Johns Hopkins University and the Johns Hopkins Hospital have named **Martin W. Donner,** MD, director of the department of radiology in the School of Medicine and radiologist-in-chief of the hospital.

A faculty member since 1958, Dr. Donner has been acting director of the department since last November.

He succeeds **Russell H. Morgan,** MD, who left the post to become dean of the Johns Hopkins medical faculty. Dr. Morgan had directed the department since its formation in 1946.

Dr. Donner, head of the department's diagnostic division since 1967, is professor of radiology in the School of Medicine and professor of radiological sciences in the Hopkins School of Hygiene and Public Health.

Dr. Donner, 51, is a native of Germany, and received his MD in 1945 from the University of Leipzig. He came to the United States in 1954, and has been at Hopkins since 1957.

•

**Stanley L. Minken,** MD, has been appointed associate chairman, department of surgery, and director of surgical education at St. Agnes Hospital, Baltimore.

Prior to assuming his new position, Dr. Minken, specialist in vascular surgery, served as associate chairman of surgery and as director of surgical outpatient services at Franklin Square Hospital in Essex.

•

**Gerald D. Klee,** MD, has been named deputy chief of psychiatry at Baltimore's Sinai Hospital. Dr. Klee assumes responsibility for the department's clinical operations, will retain his duties as director of planning, and continue in private practice.

Dr. Klee is the originator of the Sinai-Seton Program, a unique idea in short-term psychiatric care. It allows indigent patients to receive in-hospital care for up to 28 days at Seton Psychiatric Institute under Medicaid.


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Sinai Hospital's Department of Community Medicine has promoted **Leon E. Kassel,** MD, and **Howard H. Gendason,** MD. Dr. Kassel has been appointed associate chief of the department and Dr. Gendason assistant chief in the Baltimore hospital.

Dr. Kassel assumes responsibility for all departmental operations including outpatient, emergency service, and screening clinic. He also continues in private practice.

Dr. Gendason's duties include continuing care and treatment of patients in emergency service, and teaching fourth year medical students from the University of Maryland who rotate through the outpatient department.

•

**Mary E. Matthews,** MD, chief of the Division of Maternal and Child Health, Baltimore County Department of Health, has been named to the Advisory Committee of the Children's Guild, Inc. Dr. Matthews has also been elected to the board of directors of the Baltimore County 4-C Council, devoted to Community Coordinated Child Care.

•

**Hubert F. Manuzak,** MD, Glen Burnie, having successfully completed the certifying examination, has been made a Diplomate of the American Board of Family Practice.

**Abner McGehee Harvey,** MD, has been appointed to the Board of Trustees of the Passano Foundation, Baltimore. He succeeds **E. Cowles Andrus,** MD, resident member of the board for over 16 years. The board selects the Laureate for the annual Passano Award, one of the highest awards in American Medicine.

Dr. Harvey joins two other Johns Hopkins faculty members on the board: **Albert L. Lehninger,** MD, professor of physiological chemistry; and **Georgeanna Seegar Jones,** associate professor of gynecology and obstetrics.

•

**Roger Lee Olsen,** PhD, has been appointed coordinator of psychological services and coordinator of mental health services for children and adolescents for the Maryland Department of Health and Mental Hygiene.

Dr. Olsen had been associate program analyst with the Children's Bureau, State of New York Department of Mental Hygiene's Division of Mental Retardation and Children's Services in Albany, NY.

In his new position Dr. Olsen will coordinate the psychological services in Maryland mental hospitals and will oversee development of programs for children and adolescents in those hospitals and the Institute for Children.

At the annual meeting of the medical staff of the Memorial Hospital at Easton, **Vincent D. Eareckson,** MD, was elected chief of staff. A member since 1952, he succeeds **Shepard Krech,** MD.

**Callum W. Bain,** MD, has been elected vice chairman; and **Willard F. Machle Jr.,** MD, has been elected secretary-treasurer.

•

**John D. Stafford,** MD, MPH, has been appointed chief of the Maryland Department of Health and Mental Hygiene's Division of Communicable Diseases.

Dr. Stafford had been serving as acting chief following the resignation of **Howard J. Garber,** MD, at the end of 1971.

He earned his MD from the University of Maryland School of Medicine in 1968 and his MPH at the Johns Hopkins School of Public Health and Hygiene in 1971.

The division which Dr. Stafford heads deals with such vital public health concerns as immunization, VD, and the whole spectrum of epidemiology.

•

The clinical section of the laboratory at Franklin Square Hospital, Essex, is now under the direction of **Charles R. Baisden,** MD.


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# your medical faculty at work

**by John Sargeant, Executive Director**

**The Executive Committee met on Thursday, Aug 10, 1972 and took the following actions:**

1. Approved the minutes of the House of Delegates sessions held on May 3, 1972 at the Baltimore Civic Center.

2. Deferred action, at this time, in connection with an evaluation of the employees' pension program, pending receipt of additional information.

3. Approved the submission to the House of Delegates as nominees for election by the House to the Board of Directors of the Maryland Foundation for Health Care the following members of the Peer Review Committee, plus the Council Chairman:

   Arthur E. Cocco, MD, Baltimore, 1974
   Katherine H. Borkovich, MD, Baltimore, 1975
   Earl C. Clay Jr., MD, Columbia, 1973
   Clifford L. Culp, MD, Annapolis, 1975
   John R. Davis, MD, Baltimore, 1974
   Leeds E. Katzen, MD, Baltimore, 1973
   Watson P. Kime, MD, Baltimore, 1973
   Harry F. Klinefelter, MD, Baltimore, 1974
   Edward J. Kowalewski, MD, Baltimore, 1975
   Charles H. Ligon, MD, Sandy Spring, 1974
   Allan C. Woods, MD, Baltimore, 1974
   Manning W. Alden, MD, Annapolis, 1973

4. Agreed to circulate component societies for names of persons from which the President can select six additional appointees for this Board.

5. Approved the recommendation of the following physicians to the Commissioner of Motor Vehicles for appointment to the Medical Advisory Board, Department of Motor Vehicles:

   John H. Hornbaker Jr., MD, Hagerstown
   John J. Dobbie, MD, Hagerstown

6. Endorsed the objections as outlined by the California Medical Association with respect to HR1 and the Bennett amendment to that bill.

7. Referred to the Wicomico County Medical Society for its consideration objections to the Ocean City area Comprehensive Health Plan, as developed by the Eastern Shore Regional Planning Council. These objections were voiced by Robert W. Merkle, MD, who is practicing in Ocean City.

8. Determined that the Council meeting in Ocean City would be held at 4:00 PM on Thursday, Sept 14, 1972 to avoid conflict with other meetings scheduled for that evening.

9. Approved the following items submitted by the Program and Arrangements Committee (no recommendations were made by the committee):

   a) Using two of the ten free passages to Mexico City for the 1973 semiannual meeting provided by Travel Guide Agency as a raffle prize with proceeds going to AMAERF. The Woman's Auxiliary will handle all details and the prize will be awarded at the Faculty's annual meeting in 1973.

   b) Authorized continuation of the hospitality night at the annual meeting to which all members are invited.

   c) Institution on a trial basis of a past-president's dinner on the Wednesday evening during the annual session. Invited guests will include visiting state society presidents, their wives, their hosts and wives, and distinguished guests and wives. The funds for this will be taken from the President's Fund, with any overage being absorbed in the annual meeting budget.

10. Declined, at this time, to endorse a proposal of the Maryland Nurses Association dealing with a study of the Nurse Manpower in Maryland. Further details of the grant, including amount of funding being requested, will be obtained.

11. Took no action with respect to the Governor's Commission on Nursing Home interim report. The section dealing with Medical Directors for Nursing Homes has already been adopted by the Faculty as a recommendation to the Department of Health and Mental Hygiene.

12. Declined to provide time on the House of Delegates agenda in Ocean City for an address by a House officer regarding membership, because of the full agenda and lack of time available.

13. Authorized the President to circulate Associate members soliciting their wishes in connection with committee appointments.

14. Authorized the Treasurer to negotiate a dues increase for members of the Baltimore City Dental Society which are currently $5.00 per year. The last increase was in 1963, when dues were $2.50 per year.

15. Adopted 1973 Executive Committee meeting dates.

16. Made various suggestions for forwarding to the AMA regarding prototype Standards for Ambulatory Health Care Centers.

17. Heard that the Public Relations Committee considered the publication of a pamphlet outlining "Medicare Misconceptions" as an idea long overdue and that this matter would be pursued with a further recommendation to be made at a later date.

18. Authorized attendance of the following persons, with expenses to be paid from the educational fund, at the AMA Conference on Continuing Medical Education, Chicago, Oct 24-26, 1972:

    Chairman, Committee on Continuing Medical Education
    Secretary-Treasurer, Board of Medical Examiners

19. Agree to request the Council to reconsider its June 8, 1972 decision regarding immunizations against smallpox of persons "at high risk."

20. Deferred action on funding expenses of the Student AMA chapter delegates from the Johns Hopkins University School of Medicine to attend the national meeting, until the 1973 budget is prepared.

21. Determined that the Faculty Directory would continue to list both primary and secondary fields of practice of physicians. Also agreed that such directory should indicate the listing of the specialty but that this was not confirmation that the individnal physician was necessarily a specialist in the field in which he is listed.

22. Agreed to mail to all members just prior to or along with the 1973 dues bills information urging them to pay all items on the bill and including the reasons for so doing.

23. Concurred in action of the DC Medical Society urging that a regional meeting of the AMA Long-Range Planning Committee be scheduled for Washington, DC to serve this area of the state.





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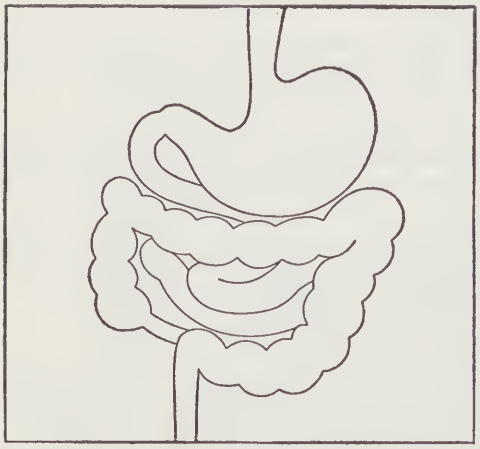
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Med-Chi Salutes

# UNIVERSITY OF MARYLAND HOSPITAL

The University of Maryland Hospital currently is a 708-bed hospital located in downtown Baltimore. The hospital is undergoing an expansion program that will result in an increase to 916 beds before the end of the year.

The original hospital was founded in 1823. It was the first hospital in the United States specifically constructed for bedside teaching of medical students.

The University of Maryland Hospital offers residency training programs in virtually all specialties.

The Outpatient Department offers a full complement of specialty clinics as well as a Family Practice Clinic.

Over 160 doctors serve on the full-time faculty and over 400 are on the attending staff.

The hospital serves as the clinical teaching environment for 560 medical students, 300 house staff, 415 student nurses, 230 graduate nurses, 25 medical secretaries, 40 pharmacy students, 15 social-work students, and numerous other allied health professions.

George H. Yeager, MD, is the hospital director. Incidentally, Dr. Yeager was the founding editor of the *Maryland State Medical Journal*, having served in that capacity from January 1952 until succeeded by the present editor, C. Thomas Flotte, MD, also a University of Maryland doctor, in October 1966.




FIREFIGHTERS? Baltimore County Fire Department surgeons were pictured recently as they received their official Fire Department automobile tags from County Executive Dale Anderson. From the left: Frank T. Barranco, MD; Robert J. Wilder, MD; Fire Chief J. Austin Deitz; Mr. Anderson; and Gustav C. Voight, MD. The fire surgeons were appointed to act as advisers to the fire chief and to the county ambulance service on medical matters.

## Predischarge Plan Being Expanded

A predischarge planning program for Medicaid patients is being expanded into three Baltimore city hospitals to handle Baltimore County patients.

The year-long project, an effort to provide a variety of services primarily for the elderly on Medicaid, is being operated in Baltimore County to centralize medical services.

The purpose of the program is to cut across agency lines and coordinate all county health care resources for patient care from initial hospitalization through the post-hospitalization period, according to Gerard D. Dobrzycki, MD, head of medical care service for the Baltimore County Department of Health.

Three city hospitals will be added to the present four county hospitals to handle the county's Medicaid patients. About 200 a month now participate.

A similar program, on a smaller scale, has been operating in Wicomico County under Regional Medical Program funding for several years, according to the Department of Health and Mental Hygiene. The department is seeking to establish these programs in every county throughout the state.

When a physician determines what services are needed for the patient, the predischarge team goes into operation. These care facilities include homemaker services, skilled and practical nursing available as soon as the patient leaves the hospital, home therapy, admission to nursing homes, temporary foster care, and psychiatric counseling.

# MEET YOUR NEW COUNCIL MEMBERS

The new Council member being profiled this month is John O. Sharrett, MD, whose office at 803 Cathedral St, Baltimore, places him in close proximity to Faculty headquarters at 1211 Cathedral St.

Dr. Sharrett was elected a Councilor for the Central District at the 1972 Annual Meeting and will assume office at the conclusion of the 1973 Annual Meeting.

His natal day was March 25, 1923. After graduating from Alleghany High School in Cumberland, he attended Mercersburg (Pa) Academy in 1940 and 1941.

After completing one term at the University of Virginia, he entered the US Army Air Force in 1942, served as a fighter pilot, and had attained the rank of Captain when he completed his military duty in 1946 and resumed his studies at the University of Virginia, graduating in 1948. He then entered the University of Maryland School of Medicine, receiving his MD in 1952.

An intensive period of training followed at University Hospital. Beginning as a rotating intern in 1952, he became assistant resident in neurological surgery in 1953, fellow in neuroanatomy and neuropathology in 1955, assistant resident in general surgery in 1956, and resident in neurological surgery in 1957. (A six-month graduate course in neurology at Queens Square in London was also included in this time period.)

He entered the private practice of neurological surgery on July 1, 1958 at his present address.



**Dr. Sharrett**

He has served as an instructor in neurological surgery at the University of Maryland School of Medicine since 1955. He became chief of neurological surgery at St. Joseph Hospital in Towson in August 1971, and assistant chief of neurological surgery at Maryland General Hospital in January 1972.

At least six Maryland hospitals number him as a consultant in neurological surgery: Bon Secours, Fort Howard VA, James Lawrence Kernan, Montebello, Peninsula General (Salisbury), and the US Public Health Service in Baltimore; also the Maryland State Penitentiary.

He has hospital privileges at these hospitals: Maryland General, St. Joseph, University, South Baltimore, Franklin Square, St. Agnes, and Mercy. He is a member of the Medical Executive Committee at Maryland General and St. Joseph hospitals.

He is a member of the Intensive Care Committee at Maryland General and of the Stroke Advisory and Review Committee, Regional Medical Program for Maryland.

At the University of Maryland he serves on the Archives Committee, Hospital Endowment Fund Committee, and Public Relations Intramural-Extramural Liaison Committee of the Medical Board. He is also a member of the Med-Chi Public Relations Committee.

Dr. Sharrett received his board certification from the American Board of Neurological Surgery in 1961, and became a Fellow in the American College of Surgeons in 1962.

In addition to AMA, Med-Chi, and Baltimore City Medical Society memberships, he is a member of the American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and the Mid-Atlantic Neurosurgical Society.

He served as 1970-1971 president of the Maryland Chapter, American College of Surgeons. And he is chairman of the Davidge Hall Restoration Fund for the University of Maryland Medical Alumni Association.

The University of Maryland Medical Alumni Association numbers him among its past presidents.

He acts as medical advisor for the Multiple Sclerosis Society of Maryland.

Dr. Sharrett is a deacon in Baltimore's Roland Park Presbyterian Church and he is on the Board of Directors of the Western Maryland Society.

A weighty and welcome addition to the Faculty Council!

## Columbia Medical Center Explained

# MEDICAL NEWS BRIEFS

The new medical center being built for the Columbia Medical Plan will grant admitting privileges to qualified non-Plan physicians practicing in Howard County.

The Board of Trustees of Columbia Hospital and Clinics Foundation announced that qualified non-Plan physicians receiving appointments at the hospital will be able to admit and treat their patients in the CMP facility.

The emergency facilities of the hospital will be open to any patient requiring those services.

In making the announcement, William F. Towle, administrator of Columbia Hospital and Clinics, said, "The provision of hospital services is so costly for the community that every effort must be made to share facilities and cooperate in their planning and use. By offering admitting privileges to qualified non-Plan physicians we hope to encourage a cooperative approach to medical care in the Howard County region."

The Columbia Medical Center is scheduled to open by April 1973. Its first phase will have 59 patient beds, a coronary care unit, general operating and delivery rooms, and an emergency department. Plans include expansion to 180 beds by the late 1970s.

Explaining that, as a general rule, patients are admitted only to those hospitals where their physicians have admitting privileges, Mr. Towle stated, "We will follow the general policy of the vast majority of hospitals throughout the country. Non-Plan physicians making applications will be granted appointments based on their credentials and qualifications, and the criteria established by the hospital's Medical Board. The Board of Trustees ultimately makes the final appointments."

Mr. Towle emphasized that the Columbia Medical Center will be a limited service facility, using the Johns Hopkins Hospital for subspecialty services that Johns Hopkins is equipped to provide.

"This policy is in keeping with the goals of the Regional Planning Council and the Comprehensive Health Planning Agency to prevent costly duplication of facilities and services and to promote a regional concept of health care delivery," Mr. Towle said.


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ORIENT ADVENTURERS—A group of 165 happy travelers including doctors, their wives, and Connie Galton and Betty Carter of the Faculty staff departed from Friendship Airport on July 23 on a Faculty-sponsored Orient Adventure. Japan, Hong Kong, and Bangkok were visited before they returned to Baltimore on August 6. This photograph, taken at a cocktail reception in the Mandarin Hotel in Hong Kong, depicts Aris T. Allen, MD, and his wife, Faye Watson Allen, MD, left, of Annapolis, talking to Dr. and Mrs. Roland Smoot, right, of Baltimore.

## Leukemia Grants

Investigators interested in pursuing careers in the field of leukemia research may apply to the Leukemia Society of America, Inc. for financial grants to support their future work.

According to Joseph H. Burchenal, MD, a Society official, applications for funding must be submitted by Nov 1, 1972. Approved grants become effective July 1, 1973.

The Society offers three types of funding to individual investigators: 1) scholarships for five-year periods, 2) special fellowships, and 3) fellowships for two years.

Application forms may be obtained by writing to the Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 E 43rd St, New York, NY 10017.

## Geriatrics Council

The American Geriatrics Society has announced the organization of a Council for Long-Term Care of Geriatric Patients "to bring together in common effort representatives of the most important groups involved in the health and welfare of the aged."

At the first meeting of the Council, Leslie S. Libow, MD, chief of geriatric medicine at Mount Sinai City Hospital Center, was elected chairman.

A Silver Spring man, Lynn W. Norris, executive vice president of the American College of Nursing Home Administrators, was elected vice chairman.

It is hoped that the new group can spearhead a united attempt to relieve the three-sided burden on the aged wherein economic, sociological, and health inadequacies are inevitably interrelated.

## St. Joseph Opens Psychiatric Unit

St. Joseph Hospital, Towson, has opened an 18-bed, short-term Psychiatric Unit, the first such facility available in the area.

Recognizing a pressing need for psychiatric inpatient care on a short-term basis, this facility was provided for in the new $2 million Acute Care Center.

Patients are admitted to the Psychiatric Unit through referral of the psychiatrists on the visiting staff of St. Joseph Hospital. One of them is on call around the clock.

The unit is directed by **E. Gordon Grau,** MD. **Richard H. Pembroke,** MD, is chief of psychiatry.

## Gundry Hospital

The Gundry Sanitarium, located at 2 N Wickham Rd, Baltimore, has been renamed the Gundry Hospital, according to the administrator, Mr. Nathan Miller.

Established in 1900 as a private psychiatric hospital in Catonsville, the Gundry Hospital offers a wide range of psychiatric services including an inpatient hospital for female patients and an outpatient and day hospital for both male and female patients.

**Rachel K. Gundry,** MD, former medical director, has retired but will continue to see patients and act as medical director emeritus.

The inpatient service is now directed by **Alfred J. Shuman,** MD. **Lino Covi,** MD, directs the outpatient service and research activities.

Mr. Miller says the hospital is proud to retain the Gundry name which represents three generations of psychiatric leadership and service to Marylanders.

## Increases Below Price Guidelines

An AMA study discloses that physicians fees increased 1.37% during the first nine months of the Economic Stabilization Program while the overall Consumer Price Index rose 2.05% during the same period.

The Physicians' Fee Index is a component of the All Services Index of the CPI. The All Services Index rose 2.16% during the nine months from September 1971 through May 1972 compared to 3.03% during the previous nine months from December 1970 through August 1971.

During the same period, the Semiprivate Hospital Room Index, a part of the All Services Index, increased by 3.84%, compared to 6.23% for the previous period.

## Medical History

A search is on for old equipment, photographs, and manuscripts that will help illustrate 200 years of physical medicine and rehabilitation practice in America. The search is a joint effort of the Smithsonian Institution, the American Congress of Rehabilitation Medicine, and the American Academy of Physical Medicine and Rehabilitation.

The Smithsonian has agreed to display an exhibit in 1973 tracing the development of this branch of medicine. The exhibit will call attention to the 50th anniversary meeting of the American Congress of Rehabilitation Medicine.

Among items being sought for the display are old canes, crutches, wheelchairs, exercise devices, heat therapy and hydrotherapy equipment, braces, splints—in short, any materials or equipment associated with the rehabilitation of the physically handicapped.

The Smithsonian Institution will pay crating and shipping charges for any equipment selected for the exhibit. In addition, the names of all donors will be listed in the exhibit catalog and will be indicated on the particular item.

The ACRM, which will hold its 50th Annual Session in Washington, DC, Oct 21-26, 1973, has invited anyone with articles of historical interest to the field of physical medicine and rehabilitation to contact Thomas P. Anderson, MD, Department of PM&R, 860 Mayo, University of Minnesota Hospitals, Minneapolis, Minn 55455.

## First Encyclopedia Of Medical Ethics

Scientists and ethicists of Protestant, Jewish, Catholic, and humanistic beliefs will write and edit the first Encyclopedia of Medical Ethics at Georgetown University in Washington, DC.

The $400,000 project will be supported by a $200,000 grant from the National Endowment for the Humanities and matching donations from the Joseph P. Kennedy Jr. Foundation and the Raskob Foundation, according to Georgetown sources.

The encyclopedia will be a three-volume comprehensive, scholarly work which will analyze, synthesize, correlate, and compare positions taken on the principles and problems of medical ethics, both traditional and contemporary. It will also point to new directions in the ethics of biomedicine. Data will be presented in encyclopedic fashion.

Emphasis will be placed on the ethics of medical personnel and the needs and rights of the patient. Certain ethical issues in population and ecological matters will also be included.

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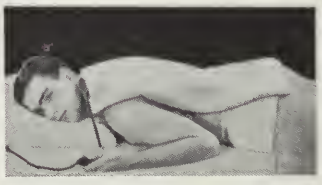
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# executive director's newsletter

October 1972

REPUBLICAN HEALTH PLATFORM

The following health plank was adopted by the Republican National Convention on Aug 22, 1972:

> Our goal is to enable every American to secure quality health care at reasonable cost. We pledge a balanced approach---one that takes into account the problems of providing sufficient medical personnel and facilities.
>
> Last year President Nixon proposed one of the most all-inclusive health programs in our history. But the opposition Congress has dragged its feet and most of this program has yet to be enacted into law.
>
> To increase the supply of medical services, we will continue to support programs to help our schools graduate more physicians, dentists, nurses, and allied health personnel with special emphasis on family practitioners and others who deliver primary medical care.
>
> We will also encourage the use of such allied personnel, as doctors' assistants foster new area health education centers, channel more services into geographic areas which now are medically deprived and improve the availability of emergency medical care.
>
> We note with pride that the President has already signed the most comprehensive health manpower legislation ever enacted.
>
> To improve efficiency in providing health and medical care, we have developed and will continue to encourage a pluralistic approach to the delivery of quality health care including innovative experiments such as health maintenance organizations. We also support efforts to develop ambulatory medical care services to reduce hospitalization and keep costs down.
>
> To reduce the cost of health care, we stress our efforts to curb inflation in the economy, we will also expand the supply of medical services and encourage greater cost consciousness in hospitalization and medical care. In doing this we realize the importance of the doctor-patient relationship and the necessity of insuring that individuals have freedom of choice of health providers.
>
> To assure access to basic medical care for all our people, we support a program financed by employers, employees and the Federal Government to provide comprehensive health insurance coverage, including insurance against the cost of long-term and catastrophic illnesses and accidents

and renal failure which necessitates dialysis, at a cost which all Americans can afford. The National Health Insurance Partnership plan and the Family Health Insurance Plan proposed by the President meet these specifications. They would build on existing private health insurance systems, not destroy them.

We oppose nationalized compulsory health insurance. This approach would at least triple in taxes the amount the average citizen now pays for health and would deny families the right to choose the kind of care they prefer. Ultimately it would lower the overall quality of health care for all Americans.

We believe that the most effective way of improving health in the long run is by emphasis on preventive measures.

The serious physical fitness problem in our country requires urgent attention. The President recently reorganized the Council on Physical Fitness and Sports to increase the leadership of representatives of medicine, physical education, sports associations and school administrations. The Republican Party urges intensification of these efforts, particularly in the Nation's school systems to encourage widespread participation in effective physical fitness programs.

We have initiated this Nation's first all-out assault against cancer. Led by the new National Cancer Institute, the drive to eliminate this cruel killer will involve Federal spending of nearly $430 million in fiscal year 1973, almost twice the funding of just two years ago.

We have also launched a major new attack on sickle cell anemia, a serious blood disorder afflicting many black Americans, and developed a comprehensive program to deal with the menace of lead-based paint poisioning, including the screening of approximately 1,500,000 Americans.

We support expanded medical research to find cures for the major diseases of the heart, blood vessels, lungs and kidneys---diseases which now account for over half of the deaths in the United States.

We have significantly advanced efforts to combat mental retardation and established a national goal to cut its incidence in half by the year 2000.

We continue to support the concept of comprehensive community mental health cneters. In this fiscal year $135 million --- almost three times the 1970 level---will be devoted to the staffing of 422 community mental health centers serving a population of 56 million people. We have intensified research on methods of treating mental problems increasing our outlays from $76 million in 1969 to approximately $96 million for 1973. We continue to urge extension of private health insurance to cover mental illness.

John Sargent
Executive Director

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### MORNING SESSION

8:00 AM **Registration**
The Physical Development Center
Coffee and Donuts—Visit Exhibits

9:00 AM **Opening Remarks**
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Catonsville Community College
Representative,
Medical and Chirurgical Faculty

9:15 AM **Anatomy and Functional Physiology of the Shoulder Joint**
Vernon E. Krahl, PhD
Professor of Anatomy
University of Maryland School of Medicine

10:00 AM **Mechanism of Injury, With Surgical and Nonsurgncal Treatment of Injuries to the Shoulder Joint**
Stanford Lavine, MD
Orthopedic Surgeon, Washington, DC
Former Orthopedic Surgeon for the Washington, DC Professional Basketball Team
Chief Physician for the University of Maryland Department of Athletics

10:45 AM **Intermission—Visit Exhibits**

11:00 AM **Symposium on Conditioning and Rehabilitation of the injured Shoulder Joint**
Mr. William Neill III, RPT
Assistant Trainer, Baltimore Colts
Director, Physical Therapy
Kernan Hospital, Baltimore, Md

Ed Block, EdD, RPT
Chief Trainer, Baltimore Colts

Mr. Otho Davis, RPT
Assistant Trainer, Baltimore Colts

12:00 Noon **Lunch—Visit the Exhibits**

### AFTERNOON SESSION

1:30 PM **Science in Sport: How to Measure and Improve Athletic Performance**
Vaughan Thomas, TC, DLC, MSc, PhD
Director of Physical Education
Liverpool Polytechnic Institute, Liverpool, England
Author of the Book by the same name, Published by Little, Brown

2:30 PM **Motivation and Communication With the High School Athlete**
Mr. Redmond C.S. Finney, BA, MEd
Headmaster, The Gilman School
Former Football Coach, The Gilman School, Baltimore, Md

3:00 PM **Motivation and Communication With the Collegiate Athlete**
Mr. Earl Banks, BS, MA
Head Football Coach
Morgan State College, Baltimore, Md.

3:30 PM **Intermission—Visit the Exhibits**

4:00 PM **Panel Discussion**

---

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**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hyperglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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*Koch-Weser, J., *et al.: Arch. Intern. Med.*, *128*:399, 1971.

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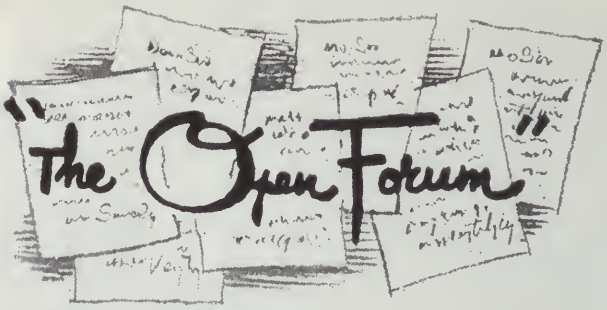
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# TOO MANY TESTS— PROVE IT!




In response to an article published in "The Open Forum" of the *Maryland State Medical Journal,* July 1972, pp 26-27, entitled "Too Many Tests?" and authored by Samuel Morrison, MD, I would like this opportunity to reiterate some of the questions presented by Dr. Morrison and further to strengthen a constructive approach to the review of many laboratory tests and procedures presently available in the physician's armamentarium.

No one will deny that the rising cost of medical care requires close appraisal by the medical profession and that a significant portion of this cost is relegated to diagnostic studies. In this regard, therefore, we thoroughly agree with Dr. Morrison that a system of audit designed to objectively evaluate the efficacy, beneficial effect, and comparative cost in the total health care scheme is mandatory. Dr. Morrison, however, in his article, is preoccupied with one specific aspect of the total problem; I fear his comments suffer from an absence of objectivity, and fall into a preoccupation with a pet peeve.

At present, many aspects of inpatient and outpatient health care delivery are being scrutinized by various groups. The bulk of this scrutiny is presently directed toward the practicing physician. His hospital charts and office records are examined for completeness and continuity of care. The Peer Review Commttee of the Medical and Chirurgical Faculty of the State of Maryland is actively involved in many aspects of physician review. This committee is in a continuing process of restructure in an effort to make a physician-run system of peer review work. At present, this process of the medical problems can be determined from solid data with resultant identification of the diagnosis, and whether the plans for treatment are appropriate to the diagnosis. Thus, comprehensive peer review needs a wide data base, if peer review as we recognize it is to be successful. "If we fail to meet this challenge of change, our profession will be managed from without."

The State of Maryland is far ahead of many states in its formulation of peer review. This fact is well recognized both locally and nationally and is to the credit of the membership, elected delegates, council members, and executive bodies in office for the past three years. This does not mean, however, that further efforts are not needed. Hopefully, through continued support of the society, the Peer Review Committee will be able to meet the challenge of the future and be able to document to all interested parties meaningful proof to support the belief that good medicine is practiced daily in the State of Maryland and that all citizens are supplied with worthwhile service.

At present, plans for the establishment of a foundation whose main function will be that of medical audit, and thus the formulation of a firm data base, are well in progress. Details will be presented to the membership in the near future. An obvious portion of this data base will be the definition of all laboratory services and diagnostic procedures. A recent proposal under discussion by the Peer Review Committee, and in keeping with its philosophy of local physician involvement with specialty interest, is presented and demonstrates the committee's concern of many problems suggested by "Too Many Tests?"

**Proposal for Hospital Based Peer Review**

PROPOSAL: Establishment of a Mechanism of Peer Review for Hospital-Based Services

Whereas, the cost of medical services are under close scrutiny by many agencies, and cost control poses a threat to the free enterprise approach to health care delivery and

Whereas, the primary physician rendering medical service is at present subject to organized efforts of PSRO, PRO, and utilization review and therefore is called upon to answer and/or explain variation in services rendered and that such review is recognized as essential in the Hospital Rules and Regulations and

Whereas, hospitals are subject to economic penalty when medical services are judged inappropriate and

Whereas, both responsible physicians and institutions are dependent upon hospital-based services for efficient and high-quality delivery of health care service and

Whereas, as it is recognized that peer review is an educational experience which is best conducted at a local environmental level by *informed authorities with similar problems,* ie, *speciality review.*

It is therefore proposed that hospitals take the initiative in the organization of a coordinate system of PRO for hospital based services to include: anesthesiology, clinical pathology, pathology, radiology, nuclear medicine, electrocardiology, pulmonary physiology, electorencephalography, emergency room service, outpatient service, nursing service, and endoscopy.

The method of organization could take many forms and those involved in the delivery of said services should be

included in the construction of any proposed structure formulation. In general, by necessity of special basic understanding of these departments, involvement will require personnel outside of the individual hospital. The latter may be accomplished in concert with other similar institutions. This approach might well serve as a broad-based educational experience, furthering the horizons of raising the standards and quality of health care delivery in this region.

Hopefully, this proposal or something similar will aid in the evaluation of many questions presented not only by Dr. Morrison but our committee and many third-party participants.

I would further point out that while each of us may be concerned with a certain pet grievance that offers us unrest in the day-to-day business of practicing medicine, it is the total problem, in the final analysis, which is important. In Dr. Morrison's case, this appears to be the problem of excessive use of endoscopic procedures. Dr. Morrison is certainly justified in his query, since I am sure more such procedures are done now than ever before. However, in the course of his article, it becomes obvious that many aspects of this problem have not been considered and, therefore, is demonstrative of the problems presented to those called upon to say what is appropriate. It should be pointed out that when any individual or group takes the responsibility to decide what is good medical practice and what is not, we must be absolutely certain that the conclusions are based upon firm medical status which takes into consideration all the facts.

Using the allegation presented concerning endoscopy as an example demonstrative of this inherent danger of not looking at all aspects let us consider the following.

Certainly all who know Dr. Morrison recognize him as an internist-gastroenterologist of repute. However, this writer is also a practicing gastroenterologist and, although without the years of experience presented by Dr. Morrison, I have been engaged in the practice of this subspecialty for the past ten years and have utilized endoscopic techniques in the evaluation of my patients frequently. It is my opinion that the criticism offered by Dr. Morrison is weak and lacks objections based on any good scientifically derived data. For example, the presented data include references 1, 2, and 3. At a glance it becomes obvious all suffer lack of documentation and are little more than one man's opinion. The single reference which hints to some fact is the reference quoted from Sandlow published in a news sheet without design of protocol or presentation of solid data. (In fairness to the question of the diagnostic use of endoscopic procedures in the management of gastrointestinal bleeding, it would seem only fair to present the views of those advocating this approach).[8,9,11,12,13]






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If we further use the endoscopic question posed as an example of how the opinion expressed may be biased one might ask: Have there been changes in the technique in recent years (in this instance since 1942)? If so, do these changes in technology merit a different set of criteria as to justification and thus utilization? Obviously, in the case of endoscopy, the most notable change has been the routine use of fiberoptic instruments.[10] As a result, visualization of the entire colon is now possible. In addition, have ancillary techniques, such as cytologic studies, combined procedures using roentography, and photographic techniques used routinely in concert altered the position of endoscopy—in other words, what is the evidence? In my opinion there is a wealth of documented information concerning each of these points; for reference one is directed to the established Journal of the American Society of Gastrointestinal Endoscopy for repeated examples of such documentation. Standard recent textbooks such as those written by Worth Boyce, MD, and by Baltimore's own Moses Paulson, MD, (who first used the instruments of Rudolph Schindler, MD) will clearly demonstrate the expanded horizon or justification of this procedure.[4,5]

Does endoscopy offer information not revealed by other techniques? To cite a few examples, in a recent presentation by B. M. Schuman, MD, a study designed to demonstrate the identification of upper gastrointestinal lesions by endoscopic study not previously demonstrated by roentgenographic techniques was found to be 20%.[6] Other studies specifically reported document this technique as being the only reliable method to demonstrate the site of gastrointestinal bleeding, mucosal disease, or neoplasm.[4-15] This debate thus far has not taken into consideration the aspect of individual proficiency, a feature I consider of prime import in quality control and self-assessment. To continue this discussion would seem of little value; therefore, let us all strive to establish an all-inclusive base from which information can be used in consideration of the individual procedure, the individual physician, the type of practice, and compare each with other similar experience.

In conclusion, to prove the point that individual authorities differ in opinion, I quote from a recent article published in the very same journal used by Dr. Morrison as his reference. The most recent authority, James A. Gregg, MD, sums up the role of endoscopy:

"Endoscopy of the upper gastrointestinal tract is an important diagnostic aid in 1) evaluating gastric and duodenal ulcers, 2) defining non-


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specific X-ray abnormalities, 3) diagnosing indeterminate upper abdominal pain, 4) evaluating the postoperative stomach, 5) determining the cause of upper gastrointestinal bleeding, and 6) evaluating the duodenum for ulcers, inflammatory disease, and periampullary malignancy. Moreover, endoscopy with cannulation of the ampulla of Vater is the only means of visualizing the pancreatic duct without surgery, locating tumors, strictures and stones in both the biliary and pancreatic ducts and aiding in the diagnosis of pancreatitis."

Now how could two authorities disagree more?

It was not the intent of this article to challenge Dr. Morrison's criticism of endoscopic procedures. Rather, we hope it has been demonstrated that a cooperative effort by all physicians is needed to establish a data base whereby anyone or any group can ask a question of medical conduct and gain meaningful answers.

ARTHUR E. COCCO, MD, Chairman
Med-Chi Peer Review Committee
20 E Eager St
Baltimore, Md 21202

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Maryland State department of health and mental hygiene

# Maryland HMOs at the Crossroads

JAMES C. ESHELMAN
Acting Director
Medical Care Programs Administration

Maryland's experience with a new concept in Comprehensive Health Delivery is one year old. It is still too early to give an indepth evaluation of the overall impact of the program on the individual enrollees or on the Maryland Medical Assistance Program. To understand some of the problems involved in any evaluation, one need only look at a definition for HMO.

An HMO is defined as "an organized health care delivery system which promotes early detection and continuity of care through an arrangement which holds a single organization responsible for assuring delivery of an agreed set of institutional physician's services to an enrolled population for a stipulated period of time in exchange for a fixed and periodic payment."

Statistics which have been gathered from other plans are unique and of little value for our needs. Unlike other plans, Maryland plans are rendering medical service to a population which is almost entirely dependent on the Medical Assistance Program for their health care. An examination of the essential features and problems of each HMO will help in arriving at a realistic conclusion.

### Program Size — Marketing and Enrollment

Current studies indicate a minimum enrollment of 10,000 to insure success of any plan. Our current enrollment (as of July) is as follows:

East Baltimore 1,822
Greater Baltimore 937
West Baltimore 2,575

No plan now in existence is hopeful of reaching the 10,000 "break even" point in the near future.

There is strong and unrefuted evidence that educational programs to explain benefits to enrollees were not vigorously undertaken, or at best undertaken as an afterthought. As a result, the total monies expended in individual out-of-plan utilization* may be inordinately high for fiscal 1972.

To have any hope for success, the plans must refuse to reimburse outside providers who render routine medical care which is covered under existing capitation rates. The plan would continue to honor any emergency care or care preauthorized by them. Enrollees who habitually go outside the plan for routine medical care would be dropped from the plan.

### Contracts and Capitation

Under existing agreements which will expire in the fall of 1972, the following capitation rates are currently in effect.

| *Enrollees* | *East Balto.* | *West Balto.* | *Greater Balto.* |
|---|---|---|---|
| Under 65 | $23.55 | $17.14 | $23.20 |
| 65 & Over | $14.37 | $ 6.25 | (Excluded from existing contract) |

The benefits in each plan are basically the same. Prescription drugs are included only by the East Baltimore Plan. Capitation rates were computed during discussions with the individual plan and were based on the best available per-capita medical information. During the initial two years contracts were undertaken with a "no loss" provision guarantee to the plan.

The existing contracts will shortly be renegotiated; some points which must be the subject of discussions are:

1) The current "no loss" provision.

*Defined as that routine medical attention which is given to the plan enrollee by providers who are not affiliated with the plan.

2) All plans must include more enrollees who are 65 and over.

3) Better communications between the plan and outside professional (medical) providers and state authorities.

4) Encourage the enrollment of patients from the private sector to allow some program balance.

5) Minimum enrollment of any plan must be established with the maximum number determined by the individual plan's ability to deliver the required services at acceptable levels of competence.

In any effort to fairly evaluate Maryland's three plans, one might ask, "Has the level of care improved for the enrollees?" The logical response might be "What does one use for a norm?" or "When compared to what?". The problem of fully evaluating our existing plans is extremely complicated. In order to make any fair analysis, we review some basic facts and assumptions.

*Fact.* The initial cost of these programs will be high because of the general health of the enrolled population.

*Assumption.* Any eventual savings will be realized in a very long-range cost saving due to fewer inpatient admissions.

*Fact.* It is difficult to sell any program on the basis of what "might be" when that program is in direct competition for state funds with programs which show concrete and immediate results (new roads, new schools, etc).

*Assumption.* What value are we ready to place on quality medical care? The poor should receive quality medical care. That medical care should certainly not be more comprehensive than that which can be afforded by the average citizen who is carrying the heaviest tax burden to support Medicaid.

National Health Insurance may be just over the hill. The climb up that hill is steep and rocky. For anyone to recommend continuation of these programs, without strong supporting evidence would be a bold move. To withdraw support because of our limited experience would also not be justified. The latter course would be particularly distasteful in light of Maryland's image as an innovator in the field of public health. The majority of health administrators feel that Health Maintenance Organizations which are properly organized, fully enrolled, and closely monitored will show not only a high level of medical care to Maryland citizens, but will also help to control the rising cost of that care.

Maryland HMOs are indeed at the crossroads.



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# Book Reviews

**REVIEW OF MEDICAL PHARMACOLOGY, by Frederick H. Meyers, MD; Ernest Jawetz, MD; and Alan Goldfien, MD; Lange Medical Publications, Los Altos, Calif, 1972.**

Learning how to think clearly about drugs is one of the medical student's most obvious and most difficult duties. The primary objective of this book is to foster a skeptical attitude toward all new drug claims and even to suggest to the practicing physician that he should occasionally reexamine his prescribing habits and critically evaluate drugs he may have been using for years. This marks the third edition of this book, which is revised every two years.

**COMPREHENSIVE REVIEW FOR THE MEDICAL ASSISTANT, By M. Murray Lawton, MD, and Donald F. Foy, MPH, The C.V. Mosby Co, St. Louis, 1972.**

This book is part of Mosby's "comprehensive review series," and attempts to be an adjunct to its more detailed companion, **A Textbook for Medical Assistants.** It provides a brief summary of the fundamentals of medical assistance and also functions as an adequate preparatory device for the medical assistant who wishes to become certified. Its thrust, however, is directed to assisting individuals who are planning to take the current certification examination. The subject matter has been largely arranged in question and answer format in order to highlight significant facts and techniques the medical assistant is likely to encounter in such examination.

**MALNUTRITION, its causation and control, Vol I and II, by John R K Robson, Gordon & Breach, New York, 1972.**

The author, experienced in the field of nutritional program planning, believes that the knowledge of nutritional science cannot be effectively applied unless it is related to physiology, pathology, human behavior, and the many factors that constitute the ecology of food and nutrition. This work is intended for students of nutrition and for professionals in the field of medicine, nursing, health, and related sciences.

**MEDICAL PHARMACOLOGY, by Andres Goth, MD, The C.V. Mosby Co, St. Louis, 1972.**

This is the sixth edition of this publication, which presents basic pharmacologic information in a manner relevant to currently favored therapeutic practices. It is selective in its coverage, giving preferential treatment to the principles and concepts needed by students and practitioners of the health professions.

**BONE TUMORS, fourth edition, by Louis Lichtenstein, MD, The C.V. Mosby Co, St. Louis, 1972.**

The format of this book has been preserved but scarcely a chapter has been left unchanged. A brief new chapter on certain rare primary tumors of bone not previously considered has been introduced, dealing notably with leiomyosarcoma and malignant mesenchymoma.

Some 40 new illustrations have been added to graphically depict new or interesting facets of many subjects, with a view to enhancing the book's usefulness.

The emphasis throughout this book is on accurate diagnosis as an essential basis for effective treatment and realistic prognosis.

The third edition was published in 1966.


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MRS. ROBERT A. REITER, Editor



# DOCTOR, HERE'S WHAT YOUR AUXILIARY DOES

It is a source of wonder to many Auxiliarians, after some twenty-odd years of work, to have doctors ask, "But what do you do?" Herewith is a fresh summary of Auxiliary endeavors.

The American Medical Association established a national woman's auxiliary in 1922 as a non-profit, public service, volunteer organization. Its purpose was to assist physicians in their work of protecting public health and providing the highest type of medical care. Since then all 50 states and the District of Columbia have organized state auxiliaries. Maryland was relatively late in joining. At the Medical and Chirurgical semiannual meeting in 1949 it was voted to establish an auxiliary to the Maryland Medical Association and since that time, 12 of Maryland's counties have organized and become a part of the state auxiliary.

Perhaps the Auxiliary's most spectacular program is fund raising the state auxiliaries do for the American Medical Association Education and Research Foundation (AMAERF). This year's donation to the Fund by the National Auxiliary was $740,388, a truly fine achievement. Maryland alone, through the untiring efforts of Elizabeth Linhardt, raised $24,000 for the fund and Maryland is one of the smaller states.

However, this is but one of many important projects. To aid in community health, the state auxiliary has a broad program divided into two sections: HEALTH EDUCATION and HEALTH SERVICES. The first includes Nutrition, Mental Health, Aging and the Homebound, and Children and Youth. Under the second the Auxiliary works on Safety, Hospital and Day Care Centers, Blood Donor Programs, and Environmental Household Management. Each county auxiliary may tailor these broad topics to fit the needs of the individual community. A chairman is appointed for each section by the state auxiliary president to work with her counterpart on the county level. To aid the state and local groups in planning and implementing their work, the national auxiliary has developed a series of "Package Programs" which are available to the county groups without charge. Package Programs now available include Alcohol, Drug Abuse, Health Manpower, Immunization, Physical Fitness, Sex Education, Smoking, Teenage Venereal Disease, and the Block Mother Plan.

Because of the national shortage of health personnel, the Auxiliary puts forth a strong effort to aid in the recruitment of such workers. By working with counselors in sponsoring high school career clubs; cooperating with guidance organizations in promoting health fairs and health career "Days"; and by getting information on health careers training programs to community groups, the Auxiliary has given impetus to the recruitment of health personnel. Raising money for scholarships to aid students in health careers is an important part of this effort. Nationally, the AMA Auxiliary has raised $5.5 million dollars for scholarships since 1952. Locally, our Maryland county auxiliaries all raise money for scholarships for nursing students. Baltimore City Auxiliary raises money for loans for third- and fourth-year medical students and over the years has raised and loaned out, without interest, more than $30,000. A major achievement, one must admit!

Also, in the field of health, it is necessary to mention the amount of aid given the so-called under-developed countries. The national auxiliary has sent tons of medical supplies and equipment and textbooks to these countries and the various state auxiliaries have supported programs such as Project Hope, Medico, Project Med-Aid, Project Concern, the Doctor to Doctor Program of the AMA, and the Thomas E. Dooley Foundation. Locally, the Maryland state auxiliary has held successful benefits for Project Hope; county auxiliaries have collected, sorted, packed, and shipped cartons of drugs; and members have made many items such as johnny

coats, plastic bed mats (crocheted from plastic strips cut from bread wrappers), various types of bandages and many other needed items. Through the untiring efforts of a Baltimore County Auxiliary member and her physician husband, truck loads of much needed materials have been shipped to a poverty stricken hospital in Honduras.

The auxiliaries, from the national level on down, all support legislation which would improve the public health and oppose measures which would adversely affect medical care. It must be kept firmly in mind, however, that the Auxiliary does no active political work. This is the province of MMPAC locally, and AMPAC nationally. What our legislative committee does is study publications received from the legislative services of AMA and then be ready, at the request of Med-Chi, to contact congressmen, letting them know of our support or opposition to certain legislation. The national auxiliary suggests that a congressman's wife has his ear when no one else does and it might be worthwhile to invite some of the wives to our meetings to hear our points of view. A firm rule of our state auxiliary is that a county group cannot contact legislators about medical legislation without the consent of their county medical society. This prohibition does not limit individuals from writing their congressman, as individuals; but, in so doing, they must not make any mention of their auxiliary or medical society. Another function of the legislative committee is to influence Auxiliary members to join MMPAC so they can work more effectively in the political arena.

In the field of publications, our state publishes a newspaper, *Hygeia Filiae,* which informs the membership concerning state and county activities, and gives sketches of county and state officers and other personnel active in projects. The editor collects newsworthy information to send to the national auxiliary publication, *MD's Wife.* Besides the state paper, each county has its own newsletter going to its own membership. Baltimore City Auxiliary's lively little paper, *The Private Lives of Doctors Wives,* hasn't missed an issue since its inception in the early days of the auxiliary.

The state auxiliary president appoints a councilor and vice councilor to the Woman's Auxiliary of the Southern Medical Association. Wives of physicians who are members of Southern Med are automatically members of its auxiliary and no dues are required. The Maryland Auxiliary takes an active part in Southern Med Auxiliary's big project, "Doctors' Day"; a project to honor doctors for their contributions to science and humanity. March 30 is the day set aside annually for this tribute. The state Doctors' Day chairman asks the Governor to proclaim March 30 as Doctors' Day, after which the county chairmen prepare programs to celebrate the occasion. The chairmen then send any photographs, programs, and write-ups of the events to the Southern Med Councilor who prepares this material for display at the Southern Medical Association Convention. All the state auxiliaries in the Association compete for awards in this exhibition; though hardly scientific, it is an interesting and pleasant part of the annual meeting.

Before closing this resumé of Auxiliary work, a word about the designation of AMAERF funds is in order. As stated earlier, Maryland has done a tremendous job in raising money for the fund, but many donors neglect to state where they wish their money to go. Such designation is allowable and desirable. Many doctors name their own medical schools or ones they are particularly interested in as recipients. Such designation is rigidly honored. If no school or research project is specified, the contribution goes into a general fund which is apportioned among the medical schools most in need.

So, doctor, your Auxiliary has a lot going for you, as this report verifies!


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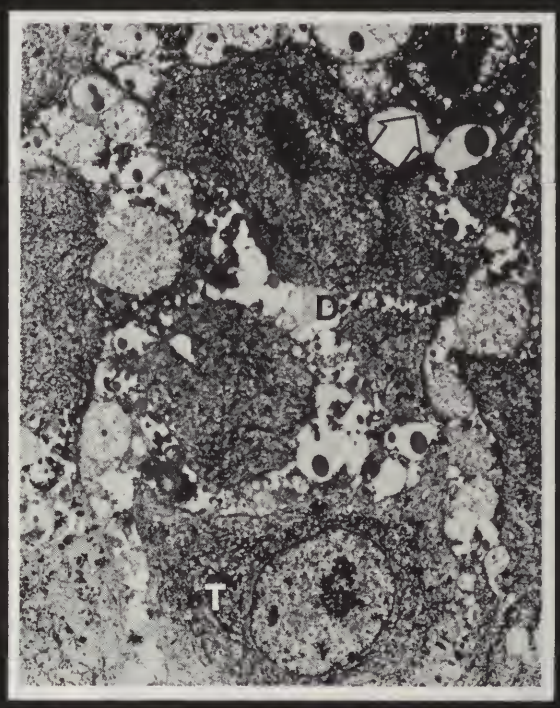
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# An Introduction to Changing Times

**EDWARD F. COTTER, MD**
**President**
**Baltimore City Medical Society**

The Baltimore City Medical Society has an outstanding record of performance in the medical affairs of Baltimore. At an earlier period in the history of the Society, the meetings were devoted to scientific programs which were accompanied by great enthusiasm and much heated discussion. In recent years, however, attendance at meetings has dwindled, leaving those responsible for the day-to-day operation of the Society uncertain and troubled about the future of the organization and the course it should take. It is no longer true, as it was at one time, that the medical scientific activities of Baltimore center around Society meetings. In recent decades, there has been a rapid proliferation of academic and scientific activity in other areas such as in the medical schools of Baltimore; the teaching hospitals within the city and adjacent areas; the growth of specialty societies, both local and national; and in the plethora of excellent postgraduate courses which are in continuous progress throughout the country.

Should the Society continue to compete in this arena or has the time arrived for the Baltimore City Medical Society and other similar societies in large metropolitan areas to direct attention to the socio-economic problems and political pressures relating to medical care in the community?

This is a debatable question, but one the Society must face and about which a decision and commitment must be made. We cannot stand still nor can we exist on the past laurels of the Society. As the problems of today press hard upon us, our members are divided with those who are ultra-conservative on the one extreme and those who are ultra-liberal on the other. There is also a large segment of the uncommitted who are possibly the silent majority of the Society whose influence may ultimately be decisive.

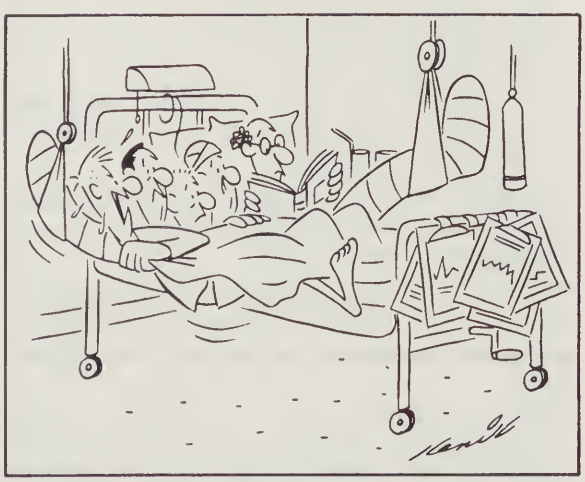
The monthly programs of the Society, both last year and this, have been directed toward presenting to the members different points of views regarding the status of medical care and changes which are occurring or impending. It was felt that these suggested changes, threatened changes, or impending changes should be discussed at regular meetings of the Society and made available to the members through publication.

The articles that follow were delivered at various meetings of the Society during the past year. Mr. Hume O. Annan and Joseph A. Mead, MD, spoke at a special meeting on "Health Care Delivery Systems" held at the Sinai Hospital in October 1971. The role of the third-party payor, as described by Mr. Annan, is playing an increasing part in the means of delivery of health care. The hospital-based group practice, as described by Dr. Mead's article, can be expected to play an important part in the development of HMOs in the future.

In January 1972 John B. De Hoff, MD, deputy commissioner, Baltimore City Health Department, discussed the status of health care in Baltimore and the Society's role in the future.

In March 1972 John H. Moxley III, MD, dean, University of Maryland School of Medicine, presented his views on the role of university medical center in the medical life of the community and the delivery of health care.

These articles will provide a broad spectrum of ideas and views on health care delivery and it is hoped that future articles will be provided on this subject.



"Next time I take out a group policy I'm looking at the small print!"

# Health Care Delivery Systems: What's Here, What's Coming

JOHN B. De HOFF, MD, MPH
Deputy Commissioner
Baltimore City Health Department
Baltimore

*From a talk presented to the Baltimore City Medical Society, Jan 6, 1972.*

Any physician may work diligently in a health care system without needing to understand its complexity or even to know that it exists. Practicing physicians are no exception. Improvement and operation or the management of orderly change require a detailed knowledge of health care delivery systems. Leadership for this society of physicians includes preparation for continuous systems planning and development, as well as service.

The system of medical cure[1] is orderly and systematized. Its stability and evolution have a base of scientific investigation and study. The delivery of health care, however, has been termed a nonsystem. Its erratic nature is due largely to a lack of scientific study and resultant disciplined activity.

A system is a set of connected, associated, or interdependent things forming a complex unity. It is many parts working together in an orderly, planned manner. The health care delivery system in which physicians work is composed of disconnected, unassociated, independent parts operating without plan or order. Even the coordinating agencies in this system are not coordinated.

Six major characteristics of a health care systems have been listed by Kerr White:[2]

First, the system should provide under one management a full range of medical services of all sorts and at all levels.

Second, the system should serve a known population, defined by geography, and by mutual commitment or enrollment.

Third, the system, apart from the physicians who practice in it, should have a corporate entity, and be legally responsible and accountable.

Fourth, there should be a unit record system throughout.

Fifth, the system should be accessible and available for needed care on a 24-hour basis, and have adequate communications systems to support it.

And, sixth, a broad range of transportation must be available for patients, specimens, records, and personnel.

While this may seem idealistic or impossible, Dr. White's requirements for a health care system were approved in an editorial written by Russell Roth, Speaker of the AMA House of Delegates. Further, these requirements for a health care system are also part of federal government proposals for improving health services.

Recommendations like these are not new, but the broad public consensus necessary for change is just now developing. Over the last 50 years professional organizations and individuals have repeatedly pointed out the need for more orderly interrelationships of health care providers. At the same time, there has been a steady improvement in the services separately provided.

Deficiencies of the system nevertheless do exist. They have persisted because of their relatively low priority for change when compared to the prime causes of sickness and death, which demanded the nearly complete attention of medical schools and physicians. Because the need to improve the vehicle for service delivery now has a high priority, this Society should insist on careful and formal studies of matters which its physician members have learned casually and informally. These include the betterment of ambulatory care, physician-hospital relationships, and cooperative service with allied health professionals and agencies. Here, the Society must be an active participant because it is a major element under study.

Pressures are now mounting to develop a full range of medical services for defined population groups, by organized and accountable provider-professionals, using modern record systems, communication, and transportation. Simply stated, these pressures come from a public with perceived needs plus the ability to pay, a classic economic definition of demand.

The public has been well educated by us and

by others; it wants its ills tended to and its health preserved; and it can pay for proper care. At least, it believed until lately that it could. Even those people who cannot be expected to pay, the obviously poor and the aged, now know what they need and have someone to pay for it. The in-between group—too rich for Medicaid, too young for Medicare, and able to afford only some episodic illness care—is now pressing for federal dollar support.

### What is Here

Government has always recognized its responsibility for the relief of serious or dangerous health needs. Money for medical research was provided by the National Institutes of Health, growing from $1.6 million in 1939 to $1.6 billion in 1966, of which about $800 million went to medical schools. In the last six years, government has provided Medicare for the elderly, Medicaid for the poor, Regional Medical Program for more rapid application of new knowledge to health care, Comprehensive Health Planning and Regional Planning Council for planning and coordination, Manpower Development and Training Act for manpower, Office of Economic Opportunity health centers for modern care in both the rural and urban ghettos, Community Mental Health to take mental illness care out of asylums, National Center for Health Services Research & Development for research and development of better systems for care, and Civilian Health and Medical Program of the Uniformed Services to provide civilian care for military dependents. Now, two-year-obligated Public Health Service young physicians are available to go into areas where there are no physicians.

Assuredly, citizens, medical schools, hospitals, and physicians have benefited from these and other government-funded health programs, but the confusions of a nonsystem still exist. Nevertheless, from these programs have come some new developments in Baltimore which should help to develop either a more orderly nonsystem or a set of synergistic systems.

A major step was taken in 1964 when the Baltimore City Health Department opened the first maternity center in the nation where any woman who was pregnant, or who thought she was, could receive a careful, complete initial workup, be referred elsewhere for delivery, and, with her newborn, be followed up. This was a bold step because it implied publicly that prenatal care in general was inadequate or untested or lacked provider coordination, and that something had to be done about it. A model program, it has attracted visitors from all over the world.

In 1966 five combined health department and hospital centers for the comprehensive health care of children and youths were opened. In 1967 the Provident Hospital was awarded a $2.5 million grant for an Office of Economic Opportunity health center of a bold new sort. This reached beyond the legally poor to people not eligible for public medical assistance, created training and jobs for allied health professionals, and involved consumers in the operation of the health center.

Rapid expansion of services, coupled with changes in the patterns of delivery, created demands for allied health manpower which had not been clearly forecast. Most of the new programs still have manpower needs which existing schools cannot completely satisfy. It is the unique nature of these needs which led to the next major advance in Baltimore. Late in 1967, Dr. Robert M. Vidaver, then Director of Education for State of Maryland Department of Mental Hygiene, proposed a partnership or consortium of health education schools and colleges, hospitals, medical societies, and health agencies. Its purposes would include the provision of interrelated or articulated courses which form career lattices, rather than career ladders, and it would provide schools with easy access to practicum sites and areas for clinical training.

The Baltimore City Medical Society is a charter member of the Maryland Consortium of the Health Sciences, with representation on the Board of Directors. The Consortium is developing programs for licensed practical nurses and registered nurses at Dunbar High School, the Community College of Baltimore, and Morgan State College. There are also several programs in mental health operating at Morgan State College, and the Consortium is working on a unique project for the Maryland Drug Abuse Administration. Plans are under way to develop integrated careers in several other fields, but one of special interest is in health administration at a baccalaureate level.

The Consortium is a Baltimore product, a "Baltimore First," if you will, and is allied with this Society. We hope to provide trained persons whom the health professions need, whom the health professionals helped to train, and whom physicians or others will employ.

In 1970 several major national organizations sensed a growing national concern for better health care delivery. The American Hospital Association set up a committee under the chairmanship of Mr. Perloff, a trustee from Philadelphia. The Perloff Committee addressed itself first to needed changes in the system. Only when

these had been set forth did the committee address the problems of financing. The American Medical Association, on the other hand, has been primarily concerned with financing, and has paid relatively little attention to system changes, in its Medicredit proposals.

The American Hospital Association recommended networks of "Health Care Corporations" which would bring all providers in designated areas together in an integrated system. In its proposal for both national and matching state legislation the American Hospital Association proposal goes further than others in suggesting plans to oversee, evaluate, and control the work of health care corporations. Physician participation in management affairs is demanded, and physicians are invited to pursue new and valid careers in health care administration, if desired.

First Maryland Health Care Corporation was formed early in 1971 by a group of hospitals, physicians, community representatives, the Baltimore City Health Department, the Consortium, and the Baltimore City Medical Society to explore the possibilities of improved health care methods in western and northern Baltimore. The corporation has been funded by Office of Economic Opportunity, and its plans call for the joint development of a community network of health care providers, concerned community groups, health agencies, and funding sources. This is a mammoth task, requiring adequate funding, professional understanding and participation, great persistence, and much patience.

In north central Baltimore, where there are several communities without physicians or dentists, a cooperative venture has also been funded to bring better care to people in this area. The North Central Baltimore Health Corporation includes several strong community groups and three hospitals.

Peripheral, but related to all these corporations, is the Maryland Health Maintenance Committee, Inc., the third of these corporations in which the Baltimore City Medical Society is a member. Health Maintenance began as a five-part committee in the fall of 1970, having representation from Blue Cross, AFL/CIO unions, Retail Stores Clerks Union, Group Health Association (Eastpoint) of Washington, and the Secretary of Health and Mental Hygiene for Maryland. It has since expanded more than tenfold and now intends to maintain an equally divided membership of providers and consumer groups or representatives. It will probably develop prepaid group practice packages and either market them or help to market them. Committed to the prepaid group practice concept, it can also develop clinical centers where it deems them necessary and negotiate contracts for hospital support, subject to control by Regional Planning Council.

Individual new ambulatory care centers include the Provident Neighborhood Comprehensive Health Center, the West Baltimore Community Health Center (independent but allied with Bon Secours Hospital), the East Baltimore Medical Center, and the Greater Baltimore Medical Center Health Center. Three of these are funded on a capitation prepaid basis by Maryland's Medicaid Program.

A small but important informal group has been MED-HEADS (Metropolitan Hospital Emergency Department Heads) which includes the physician, administrator, and nurse in charge of each Baltimore area hospital emergency department. The association meets monthly at hospitals in rotation for a Saturday breakfast meeting. Conceived by several young emergency department physicians and others in 1968, this has been a delightful vehicle to bring together a group of professionals, normally isolated and suspicious to the point of paranoia, into a friendly working group. Much of the coordination expected of local emergency services will be easier because of the activities of MED-HEADS.

In addition, independent physicians are planning medical centers in northern and northwestern Baltimore. Several other groups in west Baltimore are coalescing into a large one which will be able to build and staff major centers for the coordinated delivery of health care by private practitioners.

Hospitals such as Provident, Mercy, Johns Hopkins, Bon Secours, and Greater Baltimore Medical Center operate or support ambulatory or primary care centers, while Baltimore City Hospitals, Union Memorial, Franklin Square, Maryland General, and University hospitals are planning either separate centers or expanded primary care facilities.

Community organizations in north, east, west, and south Baltimore are now active in the development of more health care, and a major new town of Coldspring at Cylburn is in a stage of serious planning. The Baltimore City Medical Society is there through its membership in the First Maryland Health Care Corporation, the Maryland Consortium of the Health Sciences, and especially through its own efforts and interests.

The Baltimore City Health Department is

erecting a building in the Cherry Hill area for health, mental health, social services, and drug abuse programs. Several community mental health centers have also been funded elsewhere in Baltimore, new housing units have small or large medical centers, and several types of hospital-based physician groups are in formative stages.

### What is Coming

The Baltimore City Health Department has become acutely aware of need for start-up or construction and equipment funds, and has been planning to provide these in the near future through a bond issue with subsequently less expensive loans.

It should be clear by now that much preparatory work to improve the delivery of health care services has already occurred; that physicians and hospitals, communities, and government are learning to work together; and that federal funding is relatively certain.

Meanwhile, there is much ferment in the federal departments. Some eight major health bills aimed at restructuring or refunding the system have been thoroughly debated. Just what will finally be passed and signed is not clear nor is the effective date of new health legislation known. Probably the first enactment will be a compromise which will include broader coverages and firmer assurances of quality with emphasis on preventive medicine, early disease detection, and ambulatory care.

In most of the more promising bills are provisions for what is called a Health Maintenance Organization (HMO). Briefly, an HMO is an arrangement between four elements:

1) An organized health care delivery system, which includes health manpower and facilities capable of providing, or at least arranging for, all the health services a population might require.

2) An enrolled population, consisting of individual persons and groups who contract with the delivery system for provision of a range of health services which the system assumes responsibility to make available.

3) A financial plan which incorporates underwriting the costs of the agreed-upon set of services on a prenegotiated and prepaid per person or per family basis.

4) A managing organization which assures legal, fiscal, public, and professional accountability.

All four elements must be present in an HMO, and all must play an active role. Almost any responsible group may start an HMO, including consumers, elements of industry, or insurance companies. So can physicians, medical societies, or hospitals. One can see in these requirements many elements which most practicing physicians, in years past, met alone. There are others, however, which no single practitioner can provide and which require that physicians now be closer partners in a system or organization.

### Medical Societies Challenged

Clearly, the great society of physicians is now being challenged, both as it has been and as it never has been in the past. We are being challenged to help bring about what nonphysicians now know is possible, namely, better health care cooperatively delivered.

What this challenge means to physicians individually cannot be stated, but to physicians as a society, several things seem clear:

First, solo practice, except in occasional instances, will be replaced by some type of group practice. According to American Medical Association 1972 estimates, 85% of medical students plan to enter group practices.[3] The growth curve of group practices, starting from two in 1900, with a slow growth to 6,500 in 1968, shows a doubled growth in the last three years and the curve is still climbing steeply. After 1980 there will hardly be anything except group practice, according to HEW sources.

Second, HMOs will begin soon in large centers of population, encouraged by government, insurance companies, unions, strong community groups, and major hospitals.

Third, there will be a tremendous increase in the number of salaried physicians who will pose new problems for old medical societies. It is evident that they are not as concerned with malpractice, insurance, or retirement benefits but are interested in system development, management, and community relationships. Medical societies must adjust to the needs of these members or diminish in size and importance.

Fourth, in all departments of health care organizations there will be a greater number of allied health personnel to whom physicians must learn to relate positively. This requires intense consideration of the manner of health care delivery, professional relationships and roles, continuing medical education, licensing and other laws governing medical practice, and restructuring of health careers.

Fifth, hospitals will be stronger competitors in ambulatory care. Part of this new interest arises from the dependence of the American Hospital Association on income from hospital memberships at a time when hospitals are closing

in dangerously large numbers, due to bankruptcy. Individual hospitals also have economic or survival interests which are pressing them to enter the ambulatory care field. Medical care is a continuum and cannot be divided into private office practice and hospital inpatients, with hospital outpatients existing mainly for training purposes. Hospitals have been forced into expansion of existing outpatient services, due to outmigration of neighborhood physicians. They can relatively easily take the next step which simplifies hospital management by eliminating a visiting staff and depending on its own ambulatory care centers to keep hospital beds filled.

Sixth, physicians must learn to work with consumers on the governing boards of health care organizations. There must be a place for physicians on hospital governing boards for obvious reasons. Physicians must also prepare to work with true consumer representatives who are quite aware of their community's health needs.

### Leadership Role

If a medical society wishes to lead in at least some or even most of the new developments, if it is to do more than merely adjust to these changes, it must first know itself and its community well. An urban society must be attuned to the unique problems of its patients, its members and its city, if it is to survive in a rapidly changing health world.

Strength comes from the steady functioning of socially sensitive, careful workmanlike committees, operating in accordance with clearly stated policies. Society strength is based on the mutual trust and confidence. A strong society provides effective corporate society services to all members and especially at this time to the public it serves.

If this Society is to lead, if it is to be boldly in the van of medicine and its new health care delivery, we members must band together, work together, argue together. We must put different priorities on our personal activities of work and pleasure so that collectively we can put in order the health system we have been charged by society to care for.

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# Baltimore Hospital-Based Group Practice


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**Director of Ambulatory Services**
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*Summary of a talk delivered to the Baltimore City Medical Society, Oct 27, 1971. Dr. Mead is secretary-treasurer of the Mercy Medical Group.*

The redevelopment of the center of Baltimore as an area of residence, as well as commerce, has presented Mercy Hospital with the opportunity to study and develop the delivery of health care under somewhat special circumstances. Our traditional position has been to provide primary care services for a "clinic population," through our Outpatient Department, but to expect that private patients would receive their primary care in physicians' offices in the community. We have observed, however, a continued decline of such physicians' offices, in spite of the attractive development of central city.

Anticipating a deficit in primary health services for this area of Baltimore, Mercy Hospital has begun an experiment in a health care delivery system that might be applicable to other cities planning rejuvenation of their central areas.

With the aid of a grant from HEW, we have initiated a multi-specialty group practice in the well-appointed Mercy Hospital Outpatient Department. The group members are in private group practice; their offices are in the Outpatient Department. Secretarial services, examination facilities, and nursing assistance are provided by the hospital. In lieu of rent, the physicians devote onethird of their office time to the treatment of the hospital's clinic patients. The rest of their time is for the treatment of the group's private patients. The physician receives no income for the clinic patients treated, but the hospital collects its usual clinic fee—usually from Medicaid.

Thus, onethird of the physician's time, instead of onethird of his income, goes to the hospital to meet overhead expenses. The physicians receive an office, staff, and a growing source of referral from the hospital, without initial overhead expenses. He is subject to the close scrutiny of his peers through the hospital's audit and utilization mechanisms. The quality of his care is carefully observed by the hospital, jealously guarding its good name, and by the constant presence of students and house officers working in the same facilities with their own clinic patients. All laboratory examinations and X-rays are performed by the hospital's services and billed by the hospital.

Advantages to the patients include access to dignified quality of medical care without regard to economic status, personal physicians, consultations, and special studies—all located at the source of primary care, and the surveillance of quality of care by the hospital.

The program is being evaluated through the HEW grant to determine patient satisfaction, physician satisfaction, and studies of the population served, to insure equal quality of care to the poor and the economically self-sufficient. We are studying, particularly, patient referrals to the group, the percentages of missed appointments, and the number of patients requesting return visits.

These physicians, as a group, are in private practice. We are attempting to see if such a private group practice can meet the dynamic change that the city is experiencing if we weld it to the existing hospital services. We believe that the hospital cannot meet the expectations of the community by remaining enclosed within its splendid walls. Rather, the hospital should be the focal point in the community for meeting the people's needs for health care and the physician's needs for education, stimulation, and assistance with special services.

We envision a close working partnership between the hospital, the medical group, and the community-based offices—with the hospital being held accountable to the community and society for the quality and availability of medical services in the area served.

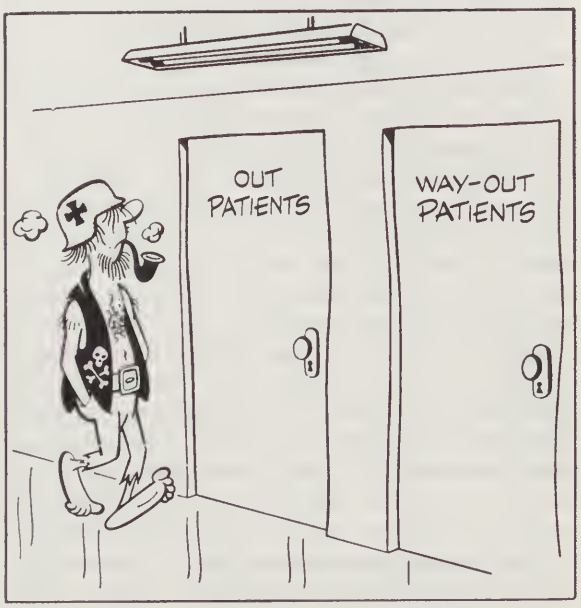
*Two audience questions are also reported here.*

**Q—Are the private and clinic patients coming to your group practice really completely integrated? Are there any services offered to one group that are not routinely offered to the other group?**

A—The private and clinic patients are completely integrated in that all are seen in the same facilities. All of the clinic patients of the hospital are not seen by the group, however. Resident physicians treat the great majority of the clinic patients; but, those that are seen by the group physicians are completely integrated into the practices of these doctors. Some hospital services are provided to the clinic patients that are not available to the group's private patients. These are, especially, subspecialty consultations which are not available in the group for private patients. Private patients requiring these consultation services are referred to private physicians in practice outside of the hospital.

**Q—Do you think that groups must be hospital based in order to succeed in the inner city, or is some kind of formal or informal relationship between the two sufficient, even if the group is located some distance from the hospital?**

A—No, I do not believe that the hospital-based arrangement is necessary, or even the best possible. I believe that the core of primary and consultation services should be provided at the hospital, and that multiple offices for primary services should be dispersed throughout the community. I am strongly convinced, however, that these physicians and groups in the community should be formally and closely linked to the hospital to 1) guarantee continuity of care, 2) provide a formal arrangement for continuing education of the practicing physicians, and 3) to insure continuing review and assurance of the quality of physicians' work. Such offices, or primary care centers, should be dispersed throughout the area served by the sponsoring hospital.



# Health Care Crisis—
# Role of Academic Medical Center

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*Talk delivered to the Baltimore City Medical Society, Feb 3, 1972.*

## Present Role

Academic medical centers in the United States have grown enormously in both size and complexity in the 27 years since World War II. Their current size and scope is difficult for many, including those of us who live in them, to keep abreast of in any detailed manner. Consequently the academic medical center, or more often one of its component parts, is often analyzed in a superficial and misleading fashion. An example, perhaps the one most frequently used, is the fact that nationally academic medical centers have expenditures of over $1.5 billion annually and yet have an undergraduate medical student body of only about 40,000 students. Simple arithmetic leads one to the assumption that it costs roughly $37,500 per student per year to produce an MD. Unfortunately the analysis often ends here with a demand that the medical school stop wasting so much money.

This financial analysis exercise is misleading because in fact the medical school does not stand alone. It is a portion of a large iceberg—it just happens to be the part that is visible at the present time largely because of the great national concern over the numbers of health manpower that are being generated. Although the education of medical students is the primary role of the medical school, it is not the only role; in turn, the medical school represents only a fraction of the total environment of the academic medical center. In addition to it there is a large hospital, several types of ambulatory services, laboratories (both clinical and research), house staff training (graduate medical education), the education of doctoral candidates in the science basic to medicine, and continuing education. Moving to the specifics at the University of Maryland Medical School and Hospital we see that in the education sphere there are 585 undergraduate medical students (an increase of over 130 since 1968), 30 graduate students, 80 postdoctoral students, 62 physical therapy students, 40 medical technology students, 16 radiology technician students, and over 350 participants in continuing education.

In terms of patient care Millis has recently pointed out that nationally academic medical centers care for one out of every nine hospitalized patients, one in seven deliveries, and one in seven ambulatory visits. All of these service statistics are on the increase, particularly the ambulatory visits. "Emergency" ambulatory visits are literally skyrocketing, having increased from 50,000 to over 70,000 in the past two years at our hospital, a hospital built in 1938 with almost no "emergency room" space.

As to research, the history and the benefits of the biomedical revolution that have occurred in the past 25 years are well known and will not be recounted here. Suffice it to say that medical schools are charged with the expenditure of well over $500 million annually for the conduct of sponsored research. If the teaching hospital's responsibility is included the total increases to upwards of $700 million. Unfortunately, despite the enormous progress that has been made in recent years both in terms of our understanding of fundamental human biology and the applications of preventive and therapeutic principles, interest in and support of research has lagged in the past few years. The declining interest of the general public and the policy makers is, strangely, shared by many in the health professions. The layman confronts disease relatively rarely and therefore cannot be expected to maintain a high interest in continuing research progress.

Not so with the health professionals. They confront disease constantly and apply the fruits of research daily. Health professionals must therefore renew their efforts to foster the continued funding of basic research. If they do not the public will suffer and so will the profession. What a sterile profession medicine would be if during a lifetime of practice one was not enriched by increasing insight into the disease process and an ever-enhanced capability to deal with it successfully.

In recent years a new dimension of responsibility has joined education, research, and service

within the academic health center. The name "extramural services" has been assigned to it. These services include participation in the organization and operation of community health services such as the Community Pediatric Center at the University of Maryland, the Inner City Community Mental Health program, and the program for teenage unwed mothers run by the university in collaboration with the Baltimore City school system. Additionally, extramural services encompass the university's participation in the Regional Medical Program and several area-wide and state-wide health planning efforts. Included at the faculty member level is participation in advising various governmental and private agencies, usually by membership on peer group advisory committees such as the study sections of the National Institutes of Health. Needless to say, with the upward spiral of interest in planning and in the organizational aspects of health care, extramural service commitments are increasing rapidly.

In summary, the current responsibilities of academic medical centers in the United States include the education and training of approximately 300,000 health professionals and technologists, the continuing education of over 100,000 physicians, the provision of about 50 million patient days of hospital care for over 3½ million patients, the care of over 400,000 newborns, the provision of approximately 20 million ambulatory visits, the conduct of $700 million worth of basic and clinical biomedical research, and the provision of around $75 million in extramural services. The responsibilities of the academic health center in 1972 certainly bear little relation to the simple Mark Hopkins and the log concept of education.

## Future Role

What about the future? The overall complexity of the mission of the academic medical center, and the resultant frustration in attempting to make progress on several fronts, has given rise to an identity crisis in academic medicine. The simpler "good old days" are, for better or worse, now a part of history. Quite clearly, the multiple roles will continue and the number will be increased.

Some broad characteristics of the present change process are apparent and can be briefly recounted.

In terms of education the demand for more and better health care will continue to stimulate a demand for more physicians. There will, therefore, continue to be an increasing focus on undergraduate medical education within the academic medical center. The result will be further increases in enrollment and further curriculum change. Both governmental and private funding of medical education have in the past several years been geared to stimulate increased enrollment and this pattern will continue. At the University of Maryland the class size has increased from 100 entering students to 137 entering students in the past few years. This fall the entering class size will be increased to 155 students, maintaining our position as one of the largest schools in the United States. The increase to 155 will exhaust the possibilities for expansion within our current physical facilities. The school is, however, committed to further increase in class size up to 200 entering students per year as soon as a building program can be completed. A detailed plan of our needs has been submitted to the state, and, hopefully, will have a high enough priority to be funded. The building program calls only for teaching and faculty space since we are optimistic that the present University of Maryland Hospital complex, plus a proposed new Veteran's Administration Hospital on our campus, and our developing affiliated community hospital program will meet our patient care educational needs. The university is anxious to expand educational opportunity in its medical school but in order to do so it must have sufficient facilities to provide assurances to all that the quality of education will not be jeopardized.

Hand in hand with expansion is curriculum innovation. The first broad phase of curriculum change was to break the so called "lock-step" of medical education and introduce "flexibility" into the curriculum usually in the form of electives. Most schools have completed this first phase and are now looking to shorten the overall time period from the completion of high school to the granting of the MD degree. A self-limiting approach to the problem is simply to compact the present medical school curriculum into a shortened time frame. Eliminating vacations and other "free time" available in each course are the methods being used. There are at least two major problems with this approach. The first is that the program moves away from an educational process toward a training program. The focus becomes training people in the tasks that they will be expected to perform at the expense of having them understand the constellation of questions that lead to the problem in the first place. In short, physician education programs tend to migrate toward physician assistant training programs.

The second major problem with the compacting approach is that most of the pruning invariably occurs in the preclinical sciences, ie, that

portion of the curriculum most oriented toward understanding and least so toward tasks. The basis of sound medical care is medical science. For medicine to turn its back on medical science in 1972 is short-sighted to say the least and could have disastrous implications for health care in the future. There is little debate about the fact that medical education is in need of innovation; the plea is that the innovation be effected creatively, not by cutting and compacting the current curriculum.

In my opinion, the concept of the "Medical University" offers the most promise. The development of this concept demands that collegiate and medical education be integrated in new ways that conserve the time and energy of students and faculty, that continue to allow for experiences in the liberal arts, and that broaden rather than restrict the understanding of the biomedical and social sciences. The sharp separation between collegiate education and medical education must be blurred; at the same time the strict time schedule of four years and four years must be broken. The ultimate result will be a logical sequence of educational experiences from high school through medical school with no sharp distinction between college and medical school. The experiences will be evaluated by the faculty in terms of the quality of achievement rather than by a required amount of time per experience. The students will be spared redundancy, will be educated rather than trained, and in large measure will be able to move at a rate of speed commensurate with capabilities and previous educational background. A major change such as the one briefly outlined here will, to say the least, be difficult. It is possible, however, and the University of Maryland and other medical schools across the country are into the planning process at the present time.

Major changes are also underway in the housestaff period of medical education. This phase, which includes internship and residency, has become recognized by the name "graduate medical education." Unfortunately it is as filled with cross currents and into change to the degree previously described for undergraduate medical education. Many of the same questions have been raised, particularly the education versus training controversy which is here further complicated by the large measure of direct service provided by the house staff.

At this juncture the emphasis is to strengthen the education component. To that end the internship as an isolated year between medical school and residency will be phased out by 1975 in order to allow the various specialties to better organize three- to five-year programs leading to specialty certification. To insure correlation of graduate medical education programs, the concept of "corporate responsibility" is being introduced. Briefly stated, corporate responsibility means that the program directors of graduate medical education within a given institution or series of affiliated institutions must plan jointly and must share the responsibility for all programs, not just their own. To sharpen the point it is likely that institutional accreditation will supplant program accreditation in the foreseeable future.

With the increased focus on education and coordination, the academic medical center will be called upon to assume overall responsibility for graduate medical education. This is not to say that programs will be limited to the academic center. Such a move would be physically impossible and philosophically incorrect for, as has been pointed out, the academic center is complex and not representative of all forms of medical practice. Rather the role of the center will be to coordinate all programs to provide assurances that they are indeed educationally oriented and that the house staff has access to a mix of experiences that will properly complete the formal period of their education. The changes in graduate medical education will put more stress on both the academic medical centers and hospitals which desire to remain in graduate medical education.

If approached constructively, however, the changes will lead to better programs and a closer working relationship between the academic medical center and the community hospitals engaged in graduate medical education. The ramifications of the closer relationship are many including the capability of expanding and enriching yet another part of medical education, continuing education of all physicians.

In terms of service, the demand for new and more efficient forms of health care has affected and will continue to affect the academic medical center. Whereas they have always maintained an intense interest in the quality of care provided to the individual patient who comes for it, the center, like all of medicine, is increasingly concerned with the overall health of populations of patients. All centers are actively at work revising their service components to make them more accessible and more acceptable to the specific community immediately around them as well as to the larger community for whom they provide referral or so-called tertiary care.

Additionally, the realization of the limitation of resources for health care is giving rise to a

rethinking of how expensive resources, such as radiation therapy centers and shock-trauma programs, might be better organized to provide for both quality and economy. In all of the service changes being contemplated the need for research and the need for cooperation and coordination between all elements of the health professions is essential. In both of these key areas the academic centers must assume major responsibility. This is not to say that they should be charged with the operational responsibility for all health services. Such a move would be inappropriate in terms of their management capability, and if attempted would undoubtedly weaken their educational programs and research programs where they have proven capability and are fulfilling a major societal need. To develop and introduce new programs is the responsibility of academic centers, to make these programs operational on a broad scale must remain the responsibility of other instruments in both the private and public sectors.

In research as indicated here, more emphasis must be given to health care research. This will include an analysis of the various levels of care, primary, secondary, and tertiary as well as the delivery forms that will provide care to all segments of our population. In Maryland we have a fairly complete spectrum of care, problems from those of the inner city of Baltimore to those of the rural areas of the Eastern Shore and Western Maryland. In all of these areas the most pressing need is for primary- or first-line care. Both the dimensions and the delivery mechanisms for primary care must be defined if progress is to be made.

Hand in hand with concern for primary care goes the development of the role of the allied health professionals, often referred to but rarely practiced as yet in team approach to the delivery of health care. To address these many problems successfully will require the spectrum of talent and the quest for inquiry that are a part of the academic medical center. Again it should be emphasized that the centers cannot and should not approach these problems in isolation but more as a coordinating focus for all of medicine, putting forth the types of expertise that they possess to work with professional societies, hospitals, and the many other elements of our society that are addressing themselves to the problem of better organizing and delivering health care.

Finally, as academic medical centers continue to expand into new areas they must remain ever mindful of their responsibility in biomedical research. As referred to before, basic research is on the verge of serious trouble because its support is not keeping abreast of inflation, much less showing real expansion. In a very real way the future potential of all of medicine is dependent on progress in the understanding of the basic mechanisms of disease. Blunting the momentum of biomedical research will do nothing but limit the capability for the advancement of medicine in all of its many spheres.

In an overview many important questions are either barely given a nod or omitted completely. This presentation suffers from both problems and in no way should be considered exhaustive. Hopefully, however, it does provide some insight into the organism known as the academic medical center, its current role, and some of the directions in which it is moving.

It is a complex organism and like the rest of medicine it must simultaneously come to grips with a myriad of problems and move forward with solutions. The solutions will not come overnight but they will come. They must come if our profession is to fulfill its calling of improving the health of all people.

## Schizophrenia Essay

An award is being offered to the medical student, intern, or resident under 30 years of age who authors the best manuscript on "Schizophrenia." The essay can be devoted to any aspect of this illness. The winner also will receive a cash prize of $250 plus travel expenses to attend and to read the Essay at the 5th Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City, Md, on April 7, 1973.

The theme of the Symposium is "Schizophrenia Around The World." Jacques Gottlieb, MD, director of the Lafayette Clinic and professor of psychiatry at Wayne State University, School of Medicine, and Robert Heath, MD, chairman, Department of Psychiatry and Neurology, Tulane University, School of Medicine, and other eminent authorities on schizophrenia from the United States and elsewhere will discuss the biochemical and physiological bases of schizophrenia and the various treatments of this illness.

An original and one copy of the double-spaced, typed manuscript (maximum 3,000 words) must be submitted by Feb 1, 1973 to Frank J. Ayd Jr., MD, symposium director, 912 W Lake Ave, Baltimore, Md. 21210. Further details of the competition may be obtained from Dr. Ayd.

# Third-Party Payor Activities In Baltimore HMOs

**HUME O. ANNAN**
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**Maryland Blue Cross, Inc.**
**Baltimore**

*Summary of a talk delivered to the Baltimore City Medical Society, Oct 27, 1971.*

Dr. Berman asked me to talk with you about changes in the health delivery system on behalf of third-party payors which includes government agencies, the insurance industry, and my own organization—Blue Cross.

Since we have a tight time schedule, let me narrow my subject and target in on just prepaid group practice.

I know that you are familiar with this type of plan as exemplified by such programs as Kaiser-Permante, HIP, Group Health Association of Washington, DC, and more recently by the Columbia Medical Plan and the Harvard Community Health Plan. But, let me briefly mention five of the common features of most prepaid group practice plans as set forth in what Dr. Ernest Seward calls a "genetic code" for this type of program.

These features are 1) the group practice of medicine; 2) reimbursement of the medical group primarily by a method other than fee-for-service, usually capitation—a set amount per member; 3) integration of ambulatory, inpatient, and other elements of comprehensive care into a system that assumes responsibility for the accessibility, continuity and quality of care; 4) a broad prepayment plan which emphasizes ambulatory and preventive benefits as well as acute inpatient care; and 5) dual choice between prepaid group practice and the prevailing fee-for-service system in which each family has the right to decide which system it prefers and the right to change from one system to another at periodic intervals.

What I have been describing is often called closed-panel practice. And it is just that. To receive benefits, members must use the service of the prepaid group practice plan, with the exception of benefits for emergency situations in which the services of the plan are not available. Free choice comes at the time of enrollment.

Now I would like to share with you the current thinking of some of the major third-party payors about this prepaid group practice system of financing and delivering health care.

Perhaps the best way to summarize the position of Blue Cross is to quote the President of the national Blue Cross Association, Walter J. McNerney. In June 1970, speaking at a special meeting of all Blue Cross Plans, Mr. McNerney said:

"The Blue Cross Association Board of Directors has taken a policy position which says that no single delivery system will suffice for a nation as diverse as ours. One worthy product that should be in the market is prepaid group practice. Blue Cross should include such a pattern in its marketing plans."

Let me summarize the attitude of the commercial insurance industry by quoting from an official publication of the Health Insurance Association of America:

"The search for efficiency and economy in the delivery of health services has led insurers to take a strong interest in prepaid group practice. This interest has found an expression in the dual-choice concept, under which each member of an insured group decides whether to receive services through a prepaid group practice plan or a fee-for-service arrangement."

In assessing the current attitude of government, there seems to be one common thread that runs through the welter of health insurance proposals now under consideration in Congress. Virtually every proposal intends to allow its beneficiaries to choose between the prevailing fee-for-service system and alternative systems using the principles of prepaid group practice.

I believe that the attitudes I have just cited represent a dramatic recent change in the thinking of most major third-party payors.

Let's look at a few of the implications of this changed attitude.

**First:** Blue Cross and insurance companies are now seeing prepaid group practice as another benefit to be marketed as part of the regular product line which they offer their customers. For their part, many prepaid group practice providers are seeing the value of using the capacities available through leading carriers of health insurance: marketing skills, administrative and underwriting resources, and systems for paying out-of-area emergency claims, for example. New marriages are being consummated

between group practice providers and third-party payors in programs like Columbia and Harvard which were unthinkable back in the early days of Kaiser and HIP.

**Second:** Insurance companies and Blue Cross are slowly working out how they can best relate to group practice and to each other so that members enrolled by Blue Cross and members enrolled by insurance companies can be effectively served by the same facilities and also so that the facilities can get enrollment from multiple sources to become financially self-sustaining as soon as possible. Subject to the forces of competition and legal considerations, cooperative arrangements between Blues and commercial insurance are being forged which were inconceivable a few years ago.

**Third:** If insurance companies and Blue Cross are to effectively market prepaid group practice as part of their regular product lines, there is a clear need for multiple centers. The employees of most major corporations and the members of most unions live in all parts of the metropolitan area. In order for them to have a meaningful dual choice, a prepaid, group-practice facility should be available within a reasonable distance of their homes. This is not to say that carriers should wait until a network of group-practice facilities is ready before going on the market—such a network will take years to develop. But it is to say that efforts to develop additional centers should proceed concurrent with the marketing of the centers that are available.

**Fourth:** I believe that all third-party payors, governmental agencies, insurance companies, and Blue Cross, are looking toward a "one class" system of medical care—which gradually eliminates the concept of one set of prepaid, group-practice centers for the poor and the aged, and another set for the privately insured population. The goal is that all enrollees, regardless of financing source, can join the same centers and receive the same quality of care. To this end, private carriers and governmental agencies are beginning to work more closely together.

Well, so much for concepts and goals. Let's look briefly at some of the things that have been done in metropolitan Baltimore so far.

• The Maryland State Department of Health and Mental Hygiene has pioneered in implementing prepaid programs for Medicaid beneficiaries.

• The West Baltimore Community Health Center, now located in Bon Secours Hospital, is operational serving Title 19 beneficiaries who have elected to receive their care from that center.

• The Greater Baltimore Medical Center facility on E Baltimore St has expanded its Children and Youth Program to include adults who are Title 19 beneficiaries.

• The East Baltimore Medical Program has opened its doors at 1031 Aisquith St and is enrolling members in adjacent housing projects. Plans are being finalized for a new center at Ensor and Eager streets which can serve a much larger area of East Baltimore.

These programs receive basic financing from Medicaid in the form of capitation payments. Additionally, for the first two years of their operation, the state will reimburse the centers for their actual costs should the capitation prove to be insufficient. If actual costs are less than capitation income, savings will be shared by the state and the center.

One program, the East Baltimore Plan, has also received funds from the 314(e) project of HEW to finance coverage for limited number of "gray area" people whose incomes are slightly above Medicaid levels but who cannot afford private health insurance. To provide protection to the East Baltimore Program against the risk of heavy inpatient utilization by 314(e) members, Blue Cross has prepared a contract which would underwrite inpatient care in excess of 30 days. In effect, this is a form of "reinsurance" for that portion of the enrollment in East Baltimore.

As another example of the growing cooperation mentioned earlier, I cite the fact the Blue Cross public relations specialists worked with the communities and institutions involved to prepare brochures describing the benefits available to Medicaid enrollees in the West Baltimore and the East Baltimore programs.

Turning from Medicaid to the private sector, the carrier which has pioneered in implementing prepaid group practice in Maryland has been the Connecticut General Life Insurance Company, which markets the Columbia Medical Plan and participates in aspects of its administration. Connecticut General has loaned mortgage money for capital financing. For a period of five years, Connecticut General has agreed, along with other participating insurers, to underwrite cash operating deficits of the Columbia Plan.

The Columbia Plan and Connecticut General have invited all other carriers licensed in Maryland to participate. Metropolitan has joined and is offering the plan to its enrollees at General Electric. Equitable recently joined. *Editor's Note: Blue Cross has since joined with the Columbia Medical Plan as a Participating Carrier.*

As of this date, Blue Cross has not yet become a Participating Carrier, primarily because its reserve and cash flow situation is not as strong as those of some insurance carriers. However, Connecticut General, after discussions with other carriers, recently made substantial modifications and improvements in the formula by which carriers amortize operating deficits and I expect that Blue Cross will be able to market the services of the Columbia Medical Plan in 1972.

There are many other prepaid group practice programs being developed in metropolitan Baltimore. On behalf of third-party payors, I would express the importance of coordinating these activities to give us a delivery system that we can offer effectively on a dual-choice basis to our members and beneficiaries.

It was to promote coordination and cooperation among the operational and developing group practice programs that Maryland Blue Cross joined in the formation of the Maryland Health Maintenance Committee, Inc. Blue Cross contributed $15,000 towards its initial expenses and has made substantial in-kind contributions of staff personnel. Other third-party payors, notably the State Department of Health and Mental Hygiene, have also made significant contributions.

The Maryland Health Maintenance Committee has established a Multi-Carrier Task Force which now contains representatives of the State Department of Health and Mental Hygiene, Connecticut General, Metropolitan, Equitable, Aetna, Travelers, and Blue Cross working toward the goals outlined earlier. Since this task force was formed in early June 1971, four meetings have been held—the first hosted by Blue Cross, the second by Metropolitan in New York, the third by the State of Maryland, and the most recent by Connecticut General in Hartford. In our current discussions, we are concentrating on basic benefit patterns that can be offered by carriers to their customers and formulas for provider reimbursement in a multiple-center format.

Let me close by saying again that I believe major third-party payors are working to make prepaid group practice generally available as a dual-choice option. But, to keep this in perspective, let me also stress that most third-party payors expects prepaid group practice to be only an alternative to the prevailing pattern which will remain fee-for-service. We believe that there is a great deal that third-party payors have done to strengthen the prevailing system and that there is a great deal more to be done.

In short, we believe that prepaid group practice is an approach which has proven itself worthy of an increased opportunity in the market place. It is not the only approach. To paraphrase Mr. McNerney—in an area as diverse as Baltimore, there is no one and only approach.

*Two audience questions are also reported here.*

**Q—Why has Maryland Blue Cross been so interested in seeing that the Health Maintenance Organization is introduced in Maryland?**

A—Maryland Blue Cross believes that HMOs of the prepaid group practice model have demonstrated the capacity to deliver comprehensive health care in a manner that can improve accessibility, continuity and cost-effectiveness, while maintaining high quality. Existing HMOs have produced significant savings in the most expensive component, inpatient hospital admissions, thereby permitting a larger share of the premium dollar to be allocated to ambulatory and preventive care.

Additionally, Blue Cross must fill the needs and wishes of its customers. There is increasing demand from major sources of Blue Cross membership, both labor and management, for prepaid group practice to be available in the Baltimore area on a dual-choice basis.

**Q—When will a prepaid group practice option actually be available to individuals in the area and from which groups will these subscribers be able to obtain care?**

A—In my talk, I outlined briefly options that are now available to Title 19 beneficiaries and through several insurance companies. Subject to final approval by the Maryland State Department of Insurance, Maryland Blue Cross expects to begin marketing its own Health Maintenance Program in 1972, offering the services of one group practice center, the Columbia Medical Plan, to employees of several group accounts. From this beginning, Blue Cross expects to move promptly on two fronts: a) marketing through other group accounts and b) adding additional prepaid group practice delivery points.

Complex negotiations still lie ahead with major Blue Cross group accounts and with providers of service in such areas as benefit patterns, premium rates, reimbursement arrangements, and risk underwriting. It is not possible to give a precise timetable. But, we expect to have other group accounts offering dual choice to their employees and more group-practice centers providing prepaid services available during 1972.

# Medical Practice and Practitioners In Eighteenth Century Maryland

**DOUGLAS CARROLL, MD**
**Baltimore City Hospitals**
**Baltimore**

*This is the seventh of an 11-part series of articles on the history of medicine in Maryland from 1634 to 1835 as written by Dr. Carroll.*

The three vignettes that follow give an insight into medical care in the eighteenth century. In the first we find how a plantation owner rendered medical care to his family and slaves. In the second, we follow the correspondence between General Otho Holland Williams and his physician Dr. Philip Thomas from 1775 to Williams' death in 1794. In these letters Williams' chronic pulmonary tuberculosis waxes and wanes as do his spirits.

Finally, there is an analysis of the Founders of the Medical and Chirurgical Faculty of Maryland. This analysis of their place of birth, educational background, and public service portrays the better type of physician practicing in Maryland in the late eighteenth century.

## HOME REMEDIES OF A MARYLAND FARMER (1803)

### Beale Bordley's recommendation to his friends

In the absence of a local physician, the responsibility for medical care often fell on the local farmer. Beale Bordley notes that on one of his farms he had 130 sick people under his care. He attempted to improve his knowledge by experience, observation, and books. One of the sources for medical information was the *American Philosophical Transactions.* He does not mention William Buchan's (1729-1805) widely used *Domestic Medicine*[1] which went through many editions in different seaboard cities between 1797 and 1816.

The following manuscript[2] is in the form of a letter addressed to his friends:

*The seashore and low, flat country of Maryland, seems to be much like the country of France which is along or near the seaside of the Bay of Biscay: and they are countries greatly disposed to affect people, especially who remove from healthy fine upland countries, with Intermittents and Remittants (fever). The intermittent fevers are generally proceeded by chills, sometimes with agues shaking the sick, and when there is no intermission, the fever becomes putrid and very dangerous, under the common name of putrid or remitting fevers. We wish our friends at Neuille may escape these in future. A tryal of the following is recommended to be made.*

*In different parts of Maryland I occupied farms of the above sickly kind. Indeed the most of the pennisula of the Chesapeak, tho' otherwise a fine country, is doomed to abound in Autumnal Intermittents, and sometimes is afflicted with Remittents, to which it is always more or less inclined, rather than to inflammatory diseases. In this common Intermittents the constant application is Emetic Tartar, to packs; sometimes Rochelle Salts, and then as an antiseptic and tonic the Jesuitt's Bark: and in general those applications suffice.*

*When the fever is now of the putrid kind, great attention is requisite, and the best antiputrescent remedies are closely applied: but as the autumnal disorders always are presumed to have a putrid tendency, regard is constantly had to that circumstance.*

*At one of my farms (no physician living near it for some years) I had to apply my little stock of experience and knowledge, to the sick of 130 in number, and made it my study to improve in the knowledge of physic, from experience, observation and books and this was the case of many gentlemen of that country.*

*I found the powder called James's Fever Powder very excellent in most cases; and I used of it, freely from the certainty that if it did no good it would do no harm— unless taken as a fool or madman might use it. It was the powder which Mr. Loriscount mentions in his book of travels in America; but having lost my written directions, I begin with giving four grains, he at once gave 24 grains, his patient was cured.*

*But respecting our Autumnal Intermittents and Remittents, I at length used to the best advantage an anticeptic medicine particularly efficacious, as discovered in Jamacia and forwarded to America. It follows:*

*Of the "Anticeptic virtues of vegetable acid and marine salt combined; in various disorders accompanied with putridity, by W. Wright M.D. in Jamacia" published in the 2 vol. Amr. Philosophical Transactions, 2 or 4.*[3]

*Dr. Wright had experienced the virtues of vegetable acid and marine salt (in Jamacia) when combined; and he recommended the following mixture — take of lime or lemon juice, three oz. (or six tablespoonsful); of common or marine salt as much as the acid will dissolve; of any simple distilled cordial water one pint; and of loaf sugar sufficient to sweeten it.*

*A wine glass full may be given to adults every two, four or six hours. (To my plantation people I gave of this medicine, differing only in giving vinegar (a vegetable acid juice), instead of lemon or lime juice; and instead of loaf, used brown sugar (yet is not loaf preferable?). First I made up the mixture in a tumbler or drinking glass, and then poured it altogether in a quart bottle, with spring water instead of distilled simple cordial water; and gave of it to the sick (oftnor): and when he was rather low in spirits, I added a little rum in the quarters; and it was thus a sort of weak punch.*

*Giving these instructions to a friend, who having business at the courts, the country people on experiencing the good effects of the medicine, gave it the name of "Paca's Punch," and it became much approved of—it is ale simple and ale is (down).*

*Dr. Wright, also in Jamacia, succeeded with it given in dysentery which there commonly begins with loose stools*

*etc, and it proved there to be beneficial in most disorders as the foundation of ale is preceeded with a disposition to putridity, and this as a powerful antiseptic medicine is essentially good. In giving of this medicine to my poor neighbors who under slow fevers were restless, and applied for opium to make them sleep: on drinking a few times of it the fever intermitted and they slept so well as to bless me for the opium put in the draught when there was not a particle of it there.*

*The amount of Dr. Wright's antiseptic medicine is fully published in the Amr. Philosoph. Transactions, at Philadelphia.*

*Recommended to my friends—July 13, 1803 Beale Bordley.*

## MEDICAL MATTERS IN THE OTHO WILLIAMS—DR. PHILIP THOMAS CORRESPONDENCE (1775-1794)

Otho Holland Williams (1749-1794) was born in Prince George's County 3/1/1749, but his family moved to what is now Washington County in 1750. Both his parents had died before he was 13 and Otho went to work in Frederick in the office of the county clerk. Around 1767 he moved to Baltimore where he stayed seven years, returning to Frederick in 1774 to go into business. With the outbreak of the Revolutionary War, he helped raise a company of riflemen and became its lieutenant. The company marched to Boston and took part in the seige. From there (Roxbury) on 10/14/1775 he wrote his friend Dr. Philip Thomas of Frederick, noting that this was his fifth or sixth letter to Thomas.

This is the first extant letter between the two and suggests a long and intimate friendship. Williams was a tall, good looking man of sanguine disposition and had a very wide friendship. He was an optimistic extrovert, prone to facetious teasing. These characteristics partially account for his rapid advance in the Continental Army through the grades of Captain to Major by November of 1776. At the assault on Fort Washington on the Hudson in that month he was wounded and captured. He was paroled to Long Island, but was charged with passing information on to General Washington, directing the rescue of prisoners on Long Island. He was never tried, but was confined in a 16-foot square room in the Provost's jail in New York City. In the same jail was Colonel Ethan Allen of Vermont, in many ways similar in outlook and character to Williams. Allen describes Williams's arrival in the prison: "In his character are united the gentleman, officer, soldier, and friend; he walked through the prison with an air of great distain; said he, 'Is this the treatment which gentlemen of the continental army are to expect from the rascally British, when in their power? Heaven forbid it!.' "[4]

Williams had been healthy prior to this time, but it seems probable that he came down at this time with pulmonary tuberculosis which was later to cause his death. In any case, when exchanged early in 1778, he was in poor health but recovered rapidly. While in prison he had been promoted to Colonel on the recommendation of John Hanson, President of the Congress of the United States, and father-in-law of Dr. Philip Thomas.

Williams went on to play an important part in the Southern Department, participating in the battles of Guilford Court House, Hobkirk Hill, and Eutaw. He was made Brigadier General 5/9/1782.

On his return to Baltimore after the fighting was over, Williams was appointed naval officer for the Port of Baltimore. With the founding of the federal government in 1789, this office was abolished and he was appointed collector of the Port of Baltimore by President Washington.

He married Mary Smith 10/18/1785 and lived an extremely happy life. By 1789 his health, which had never been good since his imprisonment, began to deteriorate with repeated pulmonary hemorrhages, gradually sapping his strength. A trip to the Barbados in the winter of 1792-93 did him no good.

In the summer of 1794, on the advice of his doctors, he started on a trip to Bath, Va for the cure, but died at Millar's Town, Va on 7/15/1794. He is buried at Williamsport, Md, a town he founded and had hoped might be the National Capitol.

Philip Thomas (1747-1815), three years older than Williams, was born near Chestertown, in Kent County on 6/11/1747. Of his medical education, he has the following to say: "I commenced the practice of Physic and Surgery, in Fredericktown on 1st August, 1769; after studying four years under Dr. Thomas Vandyke, whose talent and virtues were of sterling worth, and whose instruction and knowledge, with kindness to me, are remembered with grateful respect.

"I also attended the professional lectures, and the hospital, and a bettering house in Philadelphia, under Professors Bond, Shippen, and Morgan, from whom I obtained certificates too flattering approbatory, to induce me to stay the next season, long enough to obtain a formal diploma, as the small patrimoney left me by my father required economy. At the same time while attending the medical, I attended Dr. Smith's lectures on Natural and Experimental Philosophy, and matriculated in the college."[5] He was chairman of the Committee of Safety of Frederick County during the Revolution; Medical Purveyor of Frederick County 1781-83; and

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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# IN EDEMA*—IN HYPERTENSION*

# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg -estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg -estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg -estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. Has recurrent trichomoniasis and Monilia.
Indicates estrogen deficiency and excess of progestogen in current O.C.
1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E**® or **Ovulen**® or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.
Indicates probable need for more estrogen.
1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen**®).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.
Indicates probable progestogen excess.
1st choice: Switch to a center-spectrum pill (such as **Ovulen**®).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.
Indicates probable excess of estrogen.
1st choice: A 50 mcg.-estrogen/progestogen-dominant pill (such as **Demulen**®).



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Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

**Demulen**® a moderately progestogen-dominant O.C. for many
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**Enovid-E**® a moderately estrogen-dominant O.C. for some
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## Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in $T^3$ uptake values; metyrapone test and pregnanediol determination.

**References: 1.** Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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**Actions**—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Indication**—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

## Enovid-E®

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President of the Medical and Chirurgical Faculty of Maryland, 1801-15. In 1773, he married Jane Contee Hanson, daughter of President John Hanson. He had a number of students including his brother-in-law, Samuel Hanson, who died while serving as surgeon of General Washington's Life Guards. Another brother-in-law, Lt. Peter Contee Hanson of the 1st Battalion Maryland Infantry, Major Otho Holland Williams commanding, was killed at Fort Washington where Williams was wounded and captured. Another student, Ashton Alexander (1772-1855), married Philip Thomas' daughter, Catherine Hanson Thomas,[5,6] and was the last surviving charter member of the Medical and Chirurgical Faculty of Maryland.

**The Correspondence**

The great bulk of the letters between Thomas and Williams in the Otho Holland Williams collection are from Williams to Thomas.[7] A note on one of Williams' letters to Thomas says that Dr. Ashton Alexander had presented these letters to William E. Williams. Thus we find Williams' letters returned to his descendants. Only a few of Thomas' letters to Williams survive in the collections (#923, 945, 959, 967). These were written near the end of Williams' life and probably were not thrown out because of Williams' death.

The first extant letter from Williams to Thomas is from Roxbury, Mass (10/14/1775) and notes that it is the fifth or sixth that Williams has directed to Thomas. It is not until 1786 that the correspondence became more regular. The number of references to Williams' health gradually increases, but are always only a small part of the letters. Usually gossip and business matters between the two men take up the major space with several sentences on Williams' health frequently an afterthought. On occasion he asks medical advice, and late in his illness appears to have put himself completely under Thomas' general supervision although Thomas lived in Frederick and Williams in Baltimore.

Williams' health began to deteriorate in about 1786 with increasingly numerous episodes of coughing and hemoptysis. In 1886,[8] he tells Thomas that he is well again and goes on to chide Thomas for the use of a new "electrical machine" which Thomas had described in a previous letter. It should cause ladies to whom it is applied to vibrate, effervesce, or explode. People are going to die of quackery despite the physicians' care to expose it. In July, Williams is going to Sulphur Springs, Va at the recommendation of Dr. George Brown (1755-1822), Williams' personal physician who cared for him until his death.

On 2/24/1787,[9] Williams' son was inoculated with smallpox by Dr. John Boyd (1737-1790), a prominent local practitioner. Everything is in the boy's favor.

Several months later Williams comments[10] on a letter to the newspapers which Thomas has written supporting the Federalists. Williams considers it too respectable, lacking in the scurrilous vulgarity necessary to attract public attention. It will be read only by the few in whom reason and discretion triumph over prejudice and syncophany. Thomas is too moderate. He advises Thomas to keep his "nerves in tone." Mrs. Williams is well, and his son has already had whooping cough and small pox.

A week later Williams writes[11] regretting that Thomas has lost his child, "but you must not consider the death of an infant as a loss." Williams' own son Robert had to have four smallpox inoculations to get a good take. The pox came out and dried away for two or three weeks, but he was not very sick. Williams attributes the boy's resistance to Mrs. Williams' strong constitution. Williams had his second son, William Elie, inoculated in 1788.[12]

By 1788, Williams is beginning to have intermittent attacks of cough and rheumatism,[13] with decreasing periods of good health between. He was treated on at least one occasion[14] with a 24-hour diet of milk and water which he considers helpful.

In the fall of 1789,[15] Williams had a bad cold, "fashionably called influenza." This attack may have been part of the "epidemic putrid cold" which raged throughout the country in the fall of 1789 to the spring of 1790;[6] it may have served to exacerbate an underlying pulmonary tuberculosis which became manifest in January of 1790. A month later[16] Williams has recovered. He had heard that Thomas was sick and would have visited him had he, Williams, been well. He hopes that Thomas' son John Hanson Thomas (1779-1815) will soon be well again, but the measles in winter are obstinate.

In January 1790 he had what was probably his first hemoptysis. On the way to church he coughed and burst a small blood vessel, which flowed so fast as to demand immediate attention. He went to Dr. George Brown, but he was not home, so he went to see Dr. Moore Falls "blubbering through my mouth and nose great quantities of warm fresh blood from the lungs."[17] He then went home where he was visited by both Brown and Falls who bled him from the arm, and he is now recovered. A persistent soreness in the breast remained and was a feature of

all his subsequent attacks of hemoptysis.

Williams' physicians advised a change of climate, so he planned a trip to Sweet Springs, Va in May for six weeks.[18] He became sick with influenza of the breast, however, on a trip to New York and returned to Baltimore more reduced than at any time since his release by the British provost (in 1778).[19] He recovered rapidly[20] and was in Sweet Springs in June of 1790.[19]

A letter from Williams' father-in-law in 1793[21] tells of the typical day at a watering place. Smith was at Bath, Va in August of 1793. He arose at 5:00 AM and bathed in the waters. Then he rode horseback until breakfast. The morning was spent at billiards, followed by a sociable time of drinking the healing waters. The afternoon was spent playing whist, followed by dinner at one of his friend's cottages. The waters therefore were taken both externally and internally. Mr. Smith mentioned that he nearly choked on a piece of steak at dinner, so that alcohol and the culinary arts were also part of the cure.

Thereafter Williams was continuously sick, bothered by the "defect in my breast."[22] There was another small hemoptysis in February of 1791, treated by Dr. George Brown with phlebotomy, brought on, in Williams' opinion, by necessary application to the desk for a week.[23]

In 1792, Alexander Hamilton tells Williams[24] that he cannot consider him for an important federal position because the state of his health is a "serious objection."

In 1793, Williams went to the Barbadoes in search of health. By now he was depressed and was beginning to realize that he would never recover. He has confirmed what both Thomas and Brown told him: The better his spirits, the greater the danger of a hemorrhage.[25] While at the Barbadoes, he had a return of his old symptoms and called in a Dr. Hendy. An apothecary was directed to bleed him, and the doctor added some drops of fever medicine to the nitre which he took everyday. His pulse was 80 per minute. Hendy told him not to eat any sugar cane. Williams was already on a meat free diet. From time to time he took medicinal bark and calomel[26] and was the victim of new fads in medication.

In December 1793 he summarized his medical situation to Dr. Thomas.[27] His friends believe him to be better; he sleeps and eats well; all bodily functions are normal except his lungs; he is taking no medicine except a little paragoric for his cough; his doctors advise the strictest circumspection. For ten days he has been taking a teaspoonful of grated Indian turnip in a gill of fresh milk; it seems to help his lungs. He goes out when the weather is fine and enjoys two "segars" a day. He continues to take camomile tea, but does not like it as well as Portugese grapes.[28] He plans to take an emetic because his lungs are full of phlegm; "my breast is evidently stronger than heretofor . . . upon this I found my hopes."

Before Christmas of 1793 he caught a cold and believed he was going to have a lung hemorrhage. He got Dr. George Brown to bleed him 240 cc and had less pain and cough.[29] Williams recommends[30] Ruspine's styptic for hemoptysis. He is reconciled to his pain, but is quite melancholy.

In February 1794 he reports[31] that he has been too ill to write and finds it "hardly possible to cherish a hope of being restored."

In March he finds he has been helped by the bark.[32] Cold water causes a spasm of coughing. He likes highly seasoned food, oysters, and game birds. He wants Thomas to accept $100 for his past services and to charge him regularly as he does other people. He will follow Thomas' instructions as to diet and medicines. He has had some of Thomas' prescriptions filled at druggist Williams P. Matthew's pharmacy. He was able to ride a horse for two hours and went out to dinner. He has gotten a great deal of good from a large blister kept on for a week.[33]

Late in March he reports[34] that he met Miss Lyd in the street. She could only take his hand and burst into tears. He took a three-mile ride to Eutaw, (John Eager Howard's Estate). He suffered a chill followed by fever, and had to lie for an hour in a shanty, but felt better and came home.

The first extant letter from Thomas to Williams was written from Frederick 3/24/1794.[35] Thomas expresses his sorrow at hearing of the difficult trip to Eutaw. He advises walking as much as possible to throw the blood into the extremities and relieve the chest. He suggests a trial of cascarrillo as a substitute for the bark. He is glad Williams has tried blisters, but puts more faith in repeated emetics and exercise.

Later[36] Thomas recommends walking ten miles daily or riding 50 miles, provided there is a rest period every mile on foot and every ten miles on horseback. As soon as Mrs. Williams is recovered from her delivery, they must go to Sweet Springs. Thomas requests that they do not name the baby after him; there are others worthier.

In his last extant letter to Thomas,[37] Williams says that Thomas' sympathy and compassion please and pain him. Thomas' notion of the benefits of telling our troubles to our dearest

friends will not apply to Mrs. Williams who suffers in silence. Williams was able to ride for 35 miles. Drs. Miles Littlejohn (1758-1815) and George Brown gave him a huge emetic. Littlejohn thought him too weak to use squill. Williams awoke from a nap with a cough and hemoptysis. "In that distressing and disponding situation," he listened to a friend's advice and called in an "Empirick," an Englishman with a letter from Bishop John Carroll and Dr. Johnson recommending him. Williams liked him. The "Empirick" promised improvement in eight to ten days.

Thomas answers on 6/4/1794[38] that he is glad Williams was not alarmed by a little blood. He regrets that the emetic failed again. Thomas does not think the Empirick a quack and is not offended that Williams called him. The "Antipertussis" which Williams is using is similar to the Antimonial Wine which he used in the past and is a valuable remedy. Thomas wishes the new doctor success and asks Williams to find out what remedies he is using.

We have no other correspondence between Thomas and Williams. Williams left Baltimore for a cure at Bath, Va in July 1794 and died at Millers' Town, Va on 7/15/1794. This apparently unexpected event suggests that he had a fatal pulmonary hemorrhage.

Discussion: The Williams-Thomas correspondence gives a number of insights into medical care rendered to the upper-class, private citizen of Baltimore in the late eighteenth century. The fact that Thomas was a close friend as well as physician to Williams allowed free discussion of Williams' symptoms.

#### Pediatric Care

Infant mortality was high in Baltimore in the late eighteenth century, and the death of an infant was not to be considered a loss in Williams' condolence letter[11] to Thomas. Nevertheless, smallpox inoculation was widely practiced; Williams had his own children inoculated[9-11] and Thomas himself apparently performed 400 to 500 inoculations in Frederick in 1789.[13] Reinoculations were carried out aggressively[11] if a take did not occur. The Williams' had two local doctors, John Boyd and George Brown, but Boyd is mentioned only in connection with smallpox inoculation, whereas Brown took care of Williams' chest trouble.

Quackery was well recognized[8] and the superiority of a well-trained physician was recognized. Thomas, himself, was a well-trained physician, but he had no objection to Williams' calling in an "Empiric" doctor, presumably one trained purely in a preceptorship.[38] Williams called in a number of doctors[17,37] to treat him at different times without any suggestion of personal jealousy between doctors. These doctors seem to have accepted Thomas' suggestions as to treatment[35,37] when they were offered.

#### Williams' Illness and its Treatment

There is little doubt that Williams contracted tuberculosis in the crowded, damp Provost's prison in New York in 1777. He was sick on discharge,[19] but the tuberculosis seems to have been quiescent in 1783.[13] Possibly an attack of influenza during the epidemic of 1789[15] reactivated his tuberculosis further. From then on he had intermittent cough and hemoptysis with fever and chest pain in the later stages.

Treatment was directed toward the hemoptysis, cough, fever, and toward improving his general health and resistance. Phlebotomy was used repeatedly to treat hemoptysis[17,23] and on one occasion to prevent an expected hemorrhage.[30] The rationale for phlebotomy was to remove excessive blood by vein and prevent loss from the lungs. Thomas suggested exercise as a method of promoting removal of circulation blood from the lungs and accumulating it in his extremities.[35]

Other methods of treating hemorrhage such as starvation, a low meat diet, and the use of nitre, styptic, and emesis had a putative empirical rather than theoretical rationale.

The cough was treated on an empirical basis with antimonial wine and the "antipertussis." On one occasion,[28] an emetic was used to combat "lungs full of phlegm." In general the cough medicines of the 1790s seem to have been about as effective as those in common use today. Late in the illness, fever became more constant,[32] and Williams found little help from the bark. Thomas suggests[35] cascarillo as a substitute for bark with little effect. On one occasion, a large blister was used,[33] probably to treat the continuous breast pain. Williams felt that this treatment had benefited him greatly.

To build up his general health and resistance, Williams, on the advice of his physicians, visited Sweet Springs, Va in 1790, the Barbadoes in 1793, and was on his way to Bath, Va in 1794 when he died. He also used calamile tea, Indian turnip root, and Portugese grapes as general tonics and appetizers.

For Williams' melancholy, Thomas suggested the therapeutic benefits of talking his troubles over with one's dearest friends, but Williams felt himself unable to confide in his wife because of her silent grief.

Summary: In the Williams-Thomas correspondence we have a brief view of medical care

in the upper class in Baltimore in the late eighteenth century.

The physicians were concerned and cooperative, but had no effective tools for diagnosis or treatment of what appears to be pulmonary tuberculosis. The ebb and flow of the disease and of Williams' spirits are well exposed in these warm personal letters between a stalwart general and a distinguished physician.

## FOUNDERS OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

One of the most significant episodes in the history of medicine in Maryland is the founding of the Medical and Chirurgical Faculty in 1799. This movement was a manifestation of concern on the part of practicing physicians for improvement in medical care. Dr. Alexander Hamilton's precious diary of a journey from Baltimore to Boston in 1744 gives several interesting examples of medical practitioners (empirics) who had no education whatsoever in medicine, and yet were the only available doctors in certain rural areas.

It is of interest, therefore, that the founders of the Medical Faculty were also generally interested in improved education as well as licensure. It was for these two purposes that the Medical Faculty was founded.

A number of social factors made licensure popular and possible. The number of trained physicians was increasing through the mechanism of preceptorship and the University of Pennsylvania Medical School. Maryland towns were becoming large enough to support physicians. There was an increasingly sophisticated urban population demanding good medical care. There was a growing feeling of independence from Europe. During the Revolutionary War, Maryland, along with several other states, set up medical examining boards to test applicants for the position of Army Surgeon. This practice set a precedent for the examination of physicians going into practice. The immediate impetus to organization came from several young, ambitious, and tireless physicians recently returned from Europe.

In July of 1788 it was first suggested that a law be passed restricting the practice of medicine to qualified physicians. A petition was circulated for presentation to the General Assembly to pass laws for "the better regulation of medical practice." A plan with features similar to those of the charter of the Medical and Chirurgical Faculty of Maryland was outlined by Dr. Charles Frederick Wiesenthal but the plan lost its impetus with his death in 1789.[39]

In 1789, Dr. Andrew Wiesenthal, Charles' son, and Dr. George Buchanan, a pupil of the elder Wiesenthal, started the "Medical Society of Baltimore." This organization met with little support.

The first efforts toward the founding of a medical school were carried out by the same doctors. In 1789 under the auspices of the "Medical Society of Baltimore," an attempt was made to dissect the body of an executed criminal for the students of anatomy and surgery scattered about the town. The public got wind of this effort, became enraged at the idea of dissection, and took possession of the body thereby stopping this early attempt at human dissection.

Wiesenthal and Buchanan were not stopped by public opinion, but during the winter of 1789-90 conducted a lecture course on anatomy, surgery, and obstetrics for a class of nine students. In 1890 they organized a "Medical School" with a full faculty made up of visiting physicians to the Alms-house and used the clinical material available there. A public hospital and a lying-in hospital were recommended. Dr. Buchanan published his "Treatise on Typhus Fever" for the purpose of raising funds for the latter, but neither of these hospitals was started. The Medical Society and School both collapsed. However, Dr. Wiesenthal, in the fall of 1797, again advertised lectures on anatomy, surgery, and midwifery, but apparently this was also unsuccessful.

The Medical and Chirurgical Faculty was founded in 1799 by 101 physicians in the State of Maryland. An examination of their education, place of birth, and participation in the Revolutionary War gives some indication of what the better practitioners of the time were like.[2]

The two oldest Founders were Henry Stevenson and Upton Scott. Henry Stevenson (1721-1814) was born in England, went to Oxford University for his medical education, and then came to Baltimore to practice. During the Revolutionary War he was a Loyalist and served in the British Army as a military surgeon, returning to Baltimore following the war.

Upton Scott (1722-1814) was born in Ireland, received his MD at Glasgow in 1753 and practiced in Annapolis except for a period during the Revolutionary War when he also served in the British Army. These two doctors are representative of the highly trained European physicians who came to the colonies in the eighteenth century and represented the flower of European medical training. Both had deep loyalties to the British Empire, but both returned to Maryland following the Revolutionary War and were fully accepted and respected. Upton Scott was the

first president of the Medical and Chirurgical Faculty. Both of these doctors died in 1814 venerable and respected.

The youngest Founders were Samuel Thompson (1777-1844), Arthur Pue (1776-1847), and George Washington Purnell (1776-1844). Thompson was a graduate of the University of Pennsylvania and practiced in Queen Anne's County. Pue was the son of a doctor, attended the University of Pennsylvania in 1794, and was at Edinburgh from 1796 to 1797 but did not get his MD. He practiced in Anne Arundel County. Purnell's education is unknown but was probably through an apprenticeship with a practicing physician. Thus, these three youngest Founders represent the diversity of medical education of the day; one educated at Philadelphia receiving a MD, one attending Philadelphia and Edinburgh without attaining the MD degree, and one probably through preceptorship.

#### Place of Birth of the Founders

We have definite knowledge of the place of birth of 63 of the Founders. Fifty-one were born in Maryland, four in Pennsylvania, two in Virginia, one in Delaware, three in Scotland, one in Ireland, and one in England.

#### Preceptors

Fourteen of the preceptors of Founders are mentioned in Cordell.[6] Most of these were Maryland physicians, but Thomas Van Dyke of Philadelphia, and Dr. Smith of George Town were out-of-state preceptors. Physicians associated with the Medical School of the University of Pennsylvania (Thomas Bond and Shippen) are also mentioned. Of Maryland physicians, James Murray, Philip Thomas, John Archer, and Edward Worrell each had two Founders as apprentices. A number of other Maryland physicians taught one Founder: James Anderson, Nicholas Way, Dr. Bordley, C. F. Wiesenthal, Thomas Cradock, Dr. Hulse, and George Wallace.

Very few of the Founders attended undergraduate colleges. Two went to Princeton and one to the University of Pennsylvania.

#### Medical Schools Attended by Founders

Thirteen founders received MB or an MD at the University of Pennsylvania. Ten attended the University of Pennsylvania and did not get a degree. Two of those who received MDs from University of Pennsylvania studied at Edinburgh thereafter. One who attended the University of Pennsylvania received his MD at the Paris Medical School. Three received the MD at Edinburgh, one each at Aberdeen, Glasgow, Oxford and St. Bartholomew's. Four attended Edinburgh without receiving a degree.

Thus 23 received most of their medical education at the University of Pennsylvania, seven at University of Edinburgh, four at other English and Scottish schools, and only two at Paris.

#### War Experience

Eighteen Founders served in the Colonial Army and a number of others in the Militia. Five served in the War of 1812. James Anderson (1760-1836) served at the age of 16 in the Revolutionary Army and as a surgeon in the War of 1812. The two oldest Founders both were in the British Medical Service during the Revolutionary War.

Thus the Founders represent a group of physicians with a wide range of educational experience. The eldest represent the European trained physician who emigrated to the United States. The youngest members were educated by the local practitioner or the Medical School at the University of Pennsylvania, often topping off their education with a visit to Edinburgh. The earlier influence of Leyden had declined and the rising influence of Paris was just being felt.

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# PERIPHERAL NEUROPATHY SECONDARY TO ISONIAZID-INDUCED PYRIDOXINE DEFICIENCY

## A Case Report and Review of the Literature

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Isonicotinic acid hydrazide (isoniazid, INH) is a frequently used medication in the treatment of patients with tuberculosis. However, this therapy is not without its side effects, the most common of which is a peripheral neuropathy[1,2] which is mediated thru a deficiency of pyridoxine.[3-7] The following case report demonstrates such a side effect in a high-risk patient.

### Case Report

The patient was a poorly-nourished, 58-year-old, right-handed, black male who was admitted to the University Hospital neurology service during November 1971 for evaluation of his peripheral neuropathy.

In 1961 he underwent a partial right pneumonectomy for a tuberculous empyema and was placed on INH 300 mg PO/day. For the next ten years, until it was discontinued during August 1971, the patient received INH 300 mg daily. Prior to 1961, the patient used alcohol liberally. The patient was first seen in our clinics in 1965; at this time, and frequently thereafter, he complained of cramps, paresthesias, and weakness of all extremities distally. Because of this, the patient was treated with pyridoxine 50 mg PO daily during March 1967; he subsequently stopped this therapy after noting subjective improvement of his symptoms. He was again started on pyridoxine 50 mg PO daily during May 1968 after his ankle deep tendon reflexes (DTRs) were noted to be decreased; the pyridoxine was discontinued the following December when the ankle DTRs had returned to normal. During this time, the patient experienced a 15-lb weight loss, was treated for hypertension and acute respiratory distress and was found to have cervical spondylosis. During July 1970 he received nitrofurantoin (Macrodantin) 50 mg PO t.i.d. for prostatitis.

In January 1971 the patient again noted the onset of progressive paresthesias, dysesthesias, cramps, and weakness of all extremities distally. When seen in our Neurology Clinic on Sept 16, 1971, he was found to have a severe peripheral neuropathy involving all four extremities with distal weakness and atrophy; hypoactive DTRs at the elbows and knees, and absent DTRs at the fingers, wrists and ankles; distally decreased pain, temperature, position, and vibratory sensations; and the patient walked with the aid of a cane. He was treated with pyridoxine 50 mg PO daily and when seen again one month later, he described subjective improvement, no longer needed his cane for ambulation and his lower extremities were felt to be stronger.

On admission to the neurology service, he noted distal paresthesias, but described continued subjective improvement in his strength. General physical examination was normal except for: BP 190/120, pulse 96/min, an old right thoracotomy scar, slight scoliosis, and the liver was palpable 3 cm below the right costal margin. Neurologic exam: mental status and cranial nerves—normal. Coordination testing was impaired by the paresis. Motor and sensory—essentially unchanged from 9/16/71 and 10/21/71, except that fasciculations were noted in biceps and hand muscles.

The following laboratory values were normal: CBC, electrolytes, A/G ratio, bilirubin, cholesterol, glucose, BUN, and urine arsenic. LDH, SGOT and uric acid were slightly elevated. Urinalysis revealed hematuria and proteinuria, but creatinine clearance, 24-hour urine protein and IVP were normal. Chest X-rays showed evidence of right lower lobectomy and obstructive airway disease. EKG revealed left atrial and ventricular hypertrophy and nonspecific ST-T changes.

Nerve conduction studies, 11/12/71 and 12/14/71, of the right median, sural, and pos-

terior tibial nerves revealed a polyneuropathy, motor, and sensory, with velocities in the large fibers at the lower limits of normal. This was felt to represent an axonal type of nerve disease as opposed to one that produces primary segmental demyelination.

On the basis of the history, the physical examination and the improvement following treatment with oral pyridoxine and with discontinuance of the INH, it was felt that the patient had an isoniazid-induced pyridoxine deficient peripheral neuropathy.

## Discussion

Since its introduction in 1952, isoniazid has been reported to produce a peripheral neuropathy which is initially sensory, but may later show signs of motor involvement.[1,2,3,4,7,8,9,10,11,12] The incidence of this neuropathy is increased in poorly nourished patients who are slow inactivators of isoniazid and who are administered prolonged and/or large doses of isoniazid.[1,3,7,8,9,10,11,12] See Table 1. Clinical and histopathologic studies in rats administered large doses of isoniazid (250-350 mg/kg/day for three to 69 days) have confirmed the development of this neuropathy.[13,14,15] Pathologically, in sensory and mixed nerves of both human and rat origin, one finds primary axonal degeneration with subsequent fragmentation of the myelin sheath (wallerian degeneration) of small-medium sized fibers with sparing of large sensory fibers to the muscle spindles plus concomitant remyelination and collateral sprouting of spared motor axons terminally. This degeneration is more severe distally and may later involve the ventral roots and still later, the dorsal roots and possibly the posterior columns.[4,9,13,14,15,16] The collateral sprouting represents motor fiber regeneration and is at a sufficient rate to compensate for lost fibers; thus, clinically the neuropathy is initially and usually sensory.[9,13,16] Numerous human and rat studies have shown that this isoniazid-induced peripheral neuropathy can be prevented or later reversed with the administration of pyridoxine.[1,3,4,6,7,8,9,10,15]

Man is totally dependent on the oral intake of the $B_6$ group of vitamins which includes pyridoxine, pyridoxal and pyridoxamine.[4,6] The $B_6$ group is found in both animal and vegetable products and the average human diet is said to contain the usual daily requirement of 1.5-2.0 mg[4,6] The $B_6$ group exerts its physiologic effects after being phosphorylated to pyridoxal-5-phosphate, the most important catalytic form, which is a coenzyme for transaminase, decarboxylase, phosphorylase, deaminase, and desulfurase reactions; is involved in the metabolism of carbohydrates, protein, fat, porphyrin, iron, amino acids, and nucleic acid; and it functions in the transfer of single carbon units and in adrenocortical activity.[4,6,17] Vitamin $B_6$ deficiency has been induced in patients who received desoxypyridoxine, an antimetabolite of $B_6$, which competes with pyridoxal-5-phosphate for binding sites on the apoenzyme and blocks phosphorylation of pyridoxine and pyridoxal.[4,17] Among the signs of $B_6$ deficiency was a peripheral neuropathy which was initially sensory and later showed motor involvement; with subsequent administration of pyridoxine, the patients noted subjective improvement within 48 hours and all clinical signs and symptoms had disappeared by 21 days.[6,17] Deficiency of vitamin $B_6$ may be expected in those patients whose daily nutrition is poor and in those with increased catabolic states secondary to pregnancy, hyperthyroidism and malignancy.[4,6]

Isoniazid, too, may induce a pyridoxine deficiency.[3,4,5,7,8] INH inhibits $B_6$ dependent reactions by directly reacting with, inactivating and impairing the synthesis of pyridoxal-5-phosphate by forming hydrazones of pyridoxal which are potent inhibitors of phosphokinase which is the

**Table 1: Relationship Between Dosage of Isoniazid, Nutrition, Onset of Peripheral Neuropathy, and % of Patients Developing Peripheral Neuropathy.**

| Dosage of Isoniazid/day | Nutrition | Onset of Peripheral Neuropathy | % of patients developing a peripheral neuropathy |
|---|---|---|---|
| 3-7 mg/kg (200-500 mg/d) | not mentioned | — | .3 |
| 4.4 mg/kg (200 mg/d) | poor | 2-10 months | 1 |
| 3-5 mg/kg | not mentioned | 6 + months | 2 |
| 4-8 mg/kg (300-600 mg/d) | not mentioned | ½-39 months | — |
| 8.8 mg/kg (400 mg/d) | poor | 2-10 months | 8 |
| 6-10 mg/kg | not mentioned | 7-27 weeks | 10 |
| 4.5-13.5 mg/kg (150-750 mg/d) | not mentioned | — | 11 |
| 5-8 mg/kg (260 mg/d) | probably poor | 6 months | 14 |
| 8.8 mg/kg (400 mg/d) | poor | 2-10 months | 18 |
| 4-6 mg/kg (300 mg/d) | poor | 4-12 months | 19 |
| 11-15 mg/kg | not mentioned | 6-11 weeks | 20 |
| 12.5-15.6 mg/kg | poor | 1 year | 29 |
| 20 mg/kg | not mentioned | 16 weeks | 37 |
| 20 mg/kg | not mentioned | 4-8 weeks | 44 |

References 1, 2, 3, 4, 8, 9, 10, 11, 12

enzyme that is necessary for the phosphorylation of pyridoxine and pyridoxal.[4,6,7,8,16] The administration of isoniazid has been noted to produce an increase in urinary excretion of pyridoxal, possibly in the form of hydrazones; however, this $B_6$ loss in the urine may not be sufficient to account for the peripheral neuropathy.[3,4,5,6,7,8]

## Therapy

For those high-risk patients who receive prolonged and/or high doses of isoniazid, who have poor nutrition and consequently poor intake of pyridoxine, and who have increased catabolic states, pyridoxine 25-50 mg/day should be administered prophylactically.[18] For those patients who have already developed a peripheral neuropathy, consideration should be given to treating them with pyridoxine 50-100 mg/day and/or discontinuing their isoniazid.[2,9,11,18]

## Summary

A case is presented in which the patient developed a peripheral neuropathy secondary to isoniazid-induced pyridoxine deficiency. His motor and sensory neuropathy showed improvement when he was treated with oral pyridoxine and when the INH was discontinued.

This peripheral neuropathy is a function of dosage and duration of isoniazid therapy, the patient's general health, his nutrition, and intake of pyridoxine; such that high-risk patients are those on prolonged and/or high doses of isoniazid and who have increased catabolic states and poor nutrition with consequent poor intake of pyridoxine. For these patients, supplemental pyridoxine therapy is essential.

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## Boredom—The Self-Inflicted Sickness

A comment that caught our eye recently goes: "In a world which has become a veritable cornucopia of things to do, to see, to read, to think about, never have so many people been so bored."

Probably the saddest aspect of boredom, aside from its being self-inflicted, is that the sufferer is also self-quarantined—nobody wants to share his company. There are no simple antidotes, but there are some steps you can take should you feel yourself slipping into the slough of ennui:

1) No one who cares about people is ever bored. *Do* something for someone; you'll find it a magic pencillin for the paralysis of boredom.

2) Often boredom is a simple matter of stagnation, a reluctance to face new people, new experiences. A little bravery can win great battles in this area.

3) When learning stops, boredom walks in the door. This doesn't necessarily require the pursuit of a PhD but it does involve the stalking of some kind of knowledge with some degree of enthusiasm.

4) Finally, many psychologists claim that one primary cause of boredom today is the great availability of passive entertainment and the ease with which people slip into the habit of watching and listening to life instead of *participating* in it. Don't let yourself become a "vicarious being"—get up, get out and treat yourself to the thrill of *doing* something.



DANIEL V. LINDENSTRUTH, MD, Editor

*A Service of the Heart Association of Maryland*

**the heart page**

# Treatment of Cardiogenic Shock, II

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## Assisted Circulation

As indicated in Part I of this review, the major abnormality in cardiogenic shock is failure of the left ventricle as an effective pump. To this end considerable effort has been expended in the development of cardiac assist devices to help the left ventricle which has been damaged as a consequence of a myocardial infarction.

Many lessons concerning prolonged assisted circulation were learned from surgical procedures utilizing extracorporeal circulation. Although the heart-lung machine may take over completely the functions of oxygenation and pumping of blood, there are many limitations to this technique for patients in cardiogenic shock. The need for a thoracotomy in a critically ill patient virtually rules out any potential efficacy of this approach. In addition, the problems of hemolysis, plasma protein changes, clotting, infection, and post perfusion lung make prolonged extracorporeal circulatory techniques unfeasible for patients with cardiogenic shock.

Modifications of total extracorporeal circulatory assist have been utilized as temporary measures to help support a failing circulation. Veno-arterial pumping is one of these modifications. With this method, blood is withdrawn through a cannula introduced into the central venous system from the femoral vein. Blood is pumped into the arterial system from the femoral vein. If the venous blood is passed through an oxygenator the patient is on partial heart lung bypass for all practical purposes. If no oxygenator is utilized the procedure is much simpler but anticoagulant drugs still are necessary to prevent clotting within the system. It has been demonstrated that the lower body and extremities can tolerate prolonged periods of perfusion with venous blood.

## Left Heart Bypass

This method of assisted circulation removes oxygenated blood from the left atrium and returns it to the systemic circulation. By so doing, flow to the left ventricle is diminished by the amount removed from the left atrium. The pump is in series with the right ventricle and lungs but in parallel with the left ventricle. By reducing cardiac inflow, the distended left ventricle is given some degree of rest. It is likely that myocardial oxygen consumption is diminished as end diastolic ventricular volume and radius are decreased. Left heart bypass may be accomplished with or without thoracotomy. In the context of a patient in cardiogenic shock, a method requiring thoracotomy is obviously not feasible. As an adjunct to post-operative care this method has been utilized with some success.

A method of left heart bypass which does not require a thoracotomy has been developed. A transseptal cannula introduced into the external jugular vein is passed across the atrial septum into the left atrium. Although this method of cardiac assist was reported over ten years ago, there is still no clinical trial demonstrating its efficacy for patients after a myocardial infarction.

Although any of these forms of assisted circulation do reduce the flow work of the left ven-

tricle, it has been demonstrated that myocardial oxygen consumption is much more closely related to pressure work. A method of assisted circulation that reduced the pressure work of the left ventricle would theoretically be of considerable benefit in reducing myocardial oxygen requirements.

Arterio-arterial pumping or counterpulsation is a form of assisted circulation that can reduce the systolic pressure against which the left ventricle must pump. In addition, counterpulsation raises aortic diastolic pressure thereby increasing coronary bloodflow. In 1961 Harken, *et al,* reported on a counterpulsation device which involved cannulation of the femoral arteries. By synchronization with the electrocardiogram the pump aspirated blood from the femoral arteries during cardiac systole and returned blood to the central circulation during cardiac diastole. Considerable diastolic augmentation was achieved. Other investigators using synchronized counterpulsation in dogs found that myocardial oxygen consumption decreased by over 20% and coronary bloodflow was increased by 50%.

A variation upon the method of counterpulsation is that produced by the use of an intra-aortic balloon. This technique involves the inflation of an intra-aortic balloon at the onset of diastole and its deflation at the onset of systole. The advantages of this method are that it is totally intravascular and no blood is handled outside the body. There is less hemolysis in this technique than in counterpulsation devices which depend upon aspiration and return of blood to the vascular system for their hemodynamic effects. Heparin must be used, however, because of clotting of blood around the balloon. Rupture of the balloon with introduction of gas emboli into the vascular system is a potential hazard. Damage to the aortic wall by overdistention of the balloon may occur. Although an arteriotomy must be made for introduction of the balloon into the vascular system, there is no need for the diversion of blood through a conduit of foreign material.

Because of the desirability of having a cardiac assist device which is completely noninvasive, counterpulsation utilizing external body compression has been a goal of several groups of investigators. Such a device could be applied quickly, be free of any extracorporeal handling of blood, have no need for anticoagulants, and would not involve any operative intervention. Because of these features, it might be available to a patient earlier in the course of cardiogenic shock before prolonged hypoperfusion of vital organs made survival unlikely. Counterpulsation of the extremities involves displacement of blood retrograde into the central aorta during diastole and increasing the capacity of the arterial system during systole so as to draw blood from the aorta.

Dennis and his associates utilized a pressure sleeve on the hind limbs of dogs and applied synchronous counterpulsation. Osborn utilized a half-body pressure suit but this was found to be uncomfortable when applied to normal volunteers. Keith found similar results when human volunteers were utilized. Soroff and his associates have also evaluated external pressure suits with and without simultaneous external cardiac massage. The combination of external assist plus external cardiac massage was more successful in resuscitating dogs who were in ventricular fibrillation than was external assist alone.

In 1968 a series of physiologic studies leading to the development of an external cardiac assist device called The Sequenced Pulsator was initiated by the author and several of his colleagues. The rationale of sequenced pulsation in contrast to nonsequenced external pulsation is based on theoretical considerations underlying the effect of externally applied pressure to varying sized vessels in the extremity. Large vessels with a small wall thickness to lumen ratio more readily collapse in response to externally applied pressure than do smaller vessels which have a large wall thickness to lumen ratio. A uniformly applied external pressure to an extremity during diastole would therefore be anticipated to collapse the larger, proximal vessels first, thereby impeding return of blood to the central aorta.

The sequenced pulsator consists of arm-and-leg sections which are divided into multiple zones, each of which may be individually and separately activated to externally compress the enclosed body tissue. Activation is accomplished by inflating a chamber in each zone with compressed air. Flexible hoses connect the pressure enclosures for the arms and legs to the pressure and timing controller. The electrocardiographic signal from the patient directs the sequenced inflation of the zones through a series of solenoid valves. At the onset of the QRS complex, all pressure is simultaneously evacuated from the extremity cuffs. With such a mode the heart will never pump against a pressure wave produced by the assist device. The onset of cuff inflation can be set manually according to the length of cardiac systole. At the onset of cardiac diastole the sequenced pressure inflation is begun. By inflating the cuffs at the beginning of diastole, blood is returned to the central circulation with a consequent rise in central aortic

pressure. When the ventricle contracts there is diminished resistance in the periphery due to the previous emptying of arterial blood into the central circulation during the previous diastole. Sequenced pulsation has a milking effect upon the arterial and venous beds as pressure is applied sequentially from more distal to proximal sites. Although the sequenced pulsator has not yet been utilized in the therapy of patients in cardiogenic shock, the preliminary laboratory results indicate that external sequenced pulsation can augment cardiac output and aortic diastolic pressure.

Circulatory assist devices have the combined aim of decreasing left ventricular work and also of increasing coronary bloodflow. By so doing it is hoped that a severely damaged left ventricle may be able to compensate and take over from the support device. Since cardiogenic shock is likely to be self perpetuating once prolonged hypoperfusion of vital organs occurs, earlier application of assist devices may help certain patients in cardiogenic shock. It must be recognized, however, that even with the early application of an assist device ischemic areas of myocardium may progress to the stage of necrosis. Acute revascularization of the myocardium with a saphenous vein bypass graft may be helpful and necessary in selected cases. The role of the circulatory assist device in these instances will be to stabilize the patient while diagnostic studies such as selective coronary arteriography are performed. The success of this approach will have to be assessed as experience with saphenous vein bypass grafting increases and the long-range prognosis of the grafts becomes clearer.


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# Nineteenth Century Medicine In America

Two outstanding publications in the medical history of the nineteenth century have appeared this year, both by Baltimore-connected authors. **Medical America in the nineteenth century: readings from the literature,** by Dr. Gert H. Brieger, now associate professor of history of medicine, Duke University, Durham, NC, formerly of Johns Hopkins University Institute of the History of Medicine. In August another companion book titled **American physicians in the 19th century, from sects to science** appeared. This book is authored by Dr. William G. Rothstein, associate professor of sociology, University of Maryland Baltimore County. He holds degrees from Massachusetts Institute of Technology, the University of Minnesota, and Cornell University. Sociology of professions is his special interest.

This second book is significant for the history and sociology of the medical profession, as well as the history of the labor movement, higher education, and class structure in America. Dr. Rothstein has not attempted to include all biographical information on the outstanding leaders in the medical profession during this century, but rather has tried to trace the development of the major institutions of medical practice — the practitioner, the societies, the schools, and the licensing system. The study analyzes changes in the institutions as influences of two major causes — the medical knowledge used by physicians at certain times and the economic interest of the physicians.

While there was little increase in the volume of medical knowledge during the first half of the century, the economic situation changed greatly. Then in the latter half of the century the financial status stabilized and the volume of medical knowledge increased with the innovations in this field. Institutions established during the early part of the century underwent new changes.

After an explanation of the type of model used in this study, the author proceeds to explain that this analysis will be based on the examination of physicians who earn their livelihood from clients' fees rather than salaries or other forms of compensation.

In this phase, urbanization played a large part in developing medical practice since the economic situation of the physician was dependent upon his being able to serve a large number of clients easily in a given geographical area. Also, professional physicians had to compete with other practitioners as well as other self obtained medications.

He traces the rise of the "regular" medical profession from the colonial period to its evolution through the "heroic" period to the medical sects, such as the "botanics" and the "homeopaths," to the rise of scientific medicine.

Chronological tables giving founding dates of regular medical societies before the Civil War including the Medical & Chirurgical Faculty; medical licensing legislation in selected states before the Civil War, including Maryland; and enumerations of physicians, 1850-1900, are found in the appendixes. Hence, the book is a significant source of valuable data on medical societies, medical schools, sects, and specialties.

For several years Dr. Rothstein spent many hours in this library gathering resource information so that the staff feels particularly interested in the publication of this volume.

*(Continued next month)*

## LIBRARY MEETINGS, FALL 1972

Baltimore Hospital Librarians Association — Nov 16, 1972

Subject: **Standards for medical and nursing libraries**

Place to be announced

Medical Library Association Regional Meeting
University of Virginia, School of Medicine Library, Charlottesville, Va. Dr. Wilhelm Moll, Librarian, Host.
Oct 21, 1972

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## (lincomycin hydrochloride, Upjohn)

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Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reaction*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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# Doctors take note...

## MARYLAND AREA MEETINGS

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| Oct | 20-22 | **Heart Assoc of Md,** 25th anl mtg, Hunt Valley Inn, Md. Contact: Heart Assoc of Md, 201 N Charles St, Baltimore Md 21201, phone (301) 539-0818. |
| Oct | 27 | **Rehabilitation for Injured Workers,** 2nd anl seminar. Martins West, Baltimore, $15 regis. Contact: Miss Byrtle Bozman, Md State Dept of Educ, PO Box 8717, Baltimore Md 21240. |
| Nov | 4 | **ACP 3-State Regional Mtg** (Md-Del-DC), Howard Univ, Washington DC. Contact: Henry C Ecker MD, 916 19th St NW, Washington DC 20006. |
| Nov | 8-10 | **In-Vitro Studies in Nuclear Medicine,** Johns Hopkins Med Institutions, Baltimore. Director: HN Wagner MD. Contact: ACP, 4200 Pine St, Philadelphia Pa 19104. |
| Nov | 13-16 | **Interstate Postgrad Med Assoc of North America,** 57th Anl Scientific Assembly, Washington-Hilton Hotel, Washington DC. Primarily for family physicians & internists. $25 fee, 26 hrs instr. Contact: Alton Ochsner MD, IPMA, PO Box 5445, Madison Wisc 53705. |
| Dec | 2 | **6th Anl Medical Aspects of Sports Seminar.** Sponsors: Med-Chi & Catonsville Community College, Baltimore. |
| Apr | 25-27 | **Med-Chi 175th Anl Mtg,** Civic Center, Baltimore. |

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| Nov | 6-8 | **Current & Future Concepts in Gastroenterology,** Univ of Arizona Col of Med, Tucson. |
| Nov | 8-10 | **Internal Medicine Grand Rounds,** Mayo Clinic, Rochester, Minn. |
| Dec | 4-8 | **Advances in Diagnosis & Treatment in Clinical Medicine,** Univ Calif, Los Angeles, Disneyland Hotel, Anaheim. |

## MISCELLANEOUS MEETINGS

| | | |
|---|---|---|
| Oct | 24-26 | **Amer Col Chest Physicians,** 38th Anl Scientific Assembly, Denver. Includes 9 med symposia. Contact: ACCP, 112 E Chestnut St, Chicago Ill 60611. |
| Oct | 23-27 | **Recent Advances in Ob-Gyn,** New York City. Contact: MD Yahr MD, Columbia Univ Col of Physicians & Surgeons, 630 W 168th St, New York NY 10032. Also for 1-day crs Oct 28 on surgical techniques of laparoscopy, hysteroscopy, & culdoscopy. |
| Oct | 29-Nov 1 | **Society for Advanced Medical Systems,** Anl Mtg, Marriott Hotel, Saddle Brook NJ. Contact: Mrs. Patricia Horner, SAMS Hq, 3900 Wisconsin Ave NW, Washington DC 20016. |
| Nov | 7-10 | **Amer Col Emergency Physicians,** 4th Anl Scientific Assembly, San Francisco. Contact: ACEP, 241 E Saginaw, East Lansing Mich 48823. |
| Nov | 17-18 | **Postgrad Crs on Knee,** Col of Medicine of NJ, Newark. Contact: AE Foley, NJ Med School, 100 Bergen St, Newark NJ 07103. |
| Nov | 24-25 | **Conf on Radiology in Otolaryngology & Ophthalmology,** Chicago. Sponsor: Abraham Lincoln Sch of Med, Univ of Illinois Med Cen. Contact: GE Valvassori MD, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680. |
| Nov | 29-30 | **3d Anl Symposium for Emergency Dept Personnel,** Cherry Hill Inn, Cherry Hill NJ. Sponsors: NJ Chaptr ACEP & NJ Trauma Comm of ACS. Regis fee $40. Contact: HH Butler MD, Underwood-Memorial Hosp, Woodbury NJ 08096. |
| Dec | 2-7 | **Amer Acad of Dermatology,** 31st Anl Mtg, Americana Hotel, Bal Harbour Fla. Contact: AAD, 2250 Northwest Flanders St, Portland Ore 97210. |
| Dec | 10-13 | **Assoc of Military Surgeons of the US,** 79th Anl Conv, San Antonio. Contact: Off of Info, Aerospace Med Div, Air Force Systems Command, Brooks Air Force Base Texas. |

*"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."*

*John Galsworthy*

FREDERICK J. BALSAM, MD, Editor

**rehabilitation medicine**

# The Acutely Injured Hand and Rehabilitation

CHRIS P. TOUNTAS, MD, FAAOS
603 Chumleigh Rd
Baltimore, Md 21212

*Chief, Hand Clinic, University of Maryland Hospital; co-chief, South Baltimore General Hospital Hand Service; hand consultant, Montebello State Hospital; instructor, orthopedic surgery, University of Maryland and Johns Hopkins hospitals.*

*Information and reprint requests to Dr. Tountas.*

Rehabilitation is often one of the chief concerns of the surgeon initiating treatment of the acutely injured hand. The surgeon must ask himself whether physical methods following successful surgical treatment will produce a hand that functions satisfactorily, or should alternate surgical treatment be undertaken since the surgeon may believe that no amount of therapy will make an appreciable difference in the final result. Before making a final decision, some patient aspects should be considered: 1) age, 2) handedness, 3) occupation, 4) general health, and 5) prior upper extremity injuries.

In addition, there are often relative limiting factors placed upon the operating surgeon and his team which make it impossible for them to accomplish their goals at one sitting. The presence of other life-threatening injuries is an obvious limitation. It is also not unusual for patients with severe and complex injuries to arrive at the hospital at an hour when the physical reserve of the staff is at a low ebb. Nevertheless, it is possible to provide optimum primary care if basic principles of wound treatment are followed.

It is important to establish and maintain a soft tissue millieu that permits primary healing without infection; reconstruction without excessive fibrosis; and rehabilitation, when needed, without excessive effort.

All efforts should be directed toward minimizing scar formation. Fibrosis is an inevitable response to the disruption of connective tissue. Excessive scarring contracts skin, impedes gliding of tendons, produces ankylosis of joints, interferes with nerve function, and reduces the normal contraction of muscle.

The injured hand with an open wound should not be immersed in a detergent solution. Many germicides are irritants to the exposed tissues. In addition, the wound is further contaminated by the surrounding intact skin. Soaking, as is traditional in most emergency facilities, places the hand in a dependent position. I suggest covering the wound with a sterile pad and elevation of the hand above shoulder level. Prior to any procedure, the intact surrounding skin may be washed or scrubbed. The wound receives its toilet by debridement and copious irrigation.

When treating any acute condition of the hand, an important goal is to obtain primary wound healing. This concept of healing does not imply a need to primarily close or suture a wound. Any situation in which a wound could not reasonably be expected to heal without an excessive amount of reaction or an infection is to be avoided or delayed.

Primary tissue repair should be considered if one expects a result which will be as good or better than that which can be obtained secondarily.

The chances for a successful outcome will be enhanced by the following: 1) atraumatic technique, 2) anatomic approximation, 3) carefully placed or extended skin incisions (Fig 1), 4) use of nonreactive synthetic materials, 5) fasciotomies, 6) careful debridement, 7) careful hemostasis, 8) elevation, and 9) well-applied splints and dressings.

Generally speaking, skin lacerations of fingertip injuries can be primarily closed. Most isolated extensor tendon lacerations, at or distal to the metacarpophalangeal level, and most

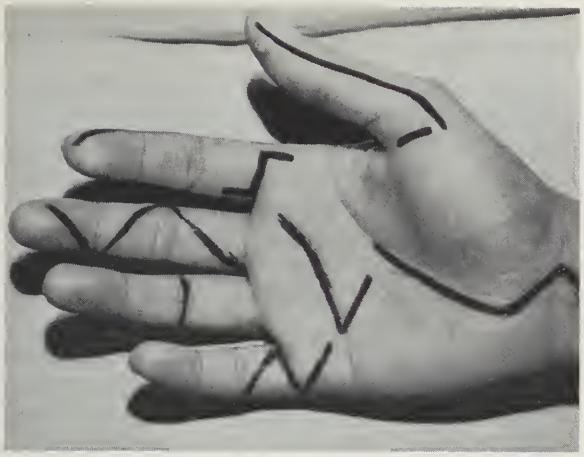


Fig 1: Hand Incisions

closed fractures can be treated in emergency or outpatient facilities. However, injuries involving skin loss, compound fractures, all flexor tendons, all nerve injuries, and multiple or complicated extensor tendon lacerations should be treated in an operating room.

The time to perform the primary procedure is within the so-called golden period. Generally and ideally, this is considered to be within six hours of the injury. Because of the generous blood supply of the hand, I believe this can be extended at least another three hours. Recently, there have been proponents of the "delayed" primary procedure. This technique implies the performance of a primary procedure within a few days following approximation of the skin edges without subsequent evidence of an infection.

When vascularity of a part is not jeopardized, a pneumatic arm tourniquet will be of inestimable value during the technical performance of an operative procedure. The arm should be padded, the hand and forearm expressed of venous blood, and then the tourniquet inflated to prevent arterial flow. The pressure commonly used is between 275-300 mm Hg. It is probably safe to permit inflation for one and one half hours. If extended periods are necessary, deflation of from 15 to 20 minutes will permit reinflation of the tourniquet for at least another hour. A digital elastic tourniquet is not recommended because the amount of compression cannot be measured.

Hemostasis is more efficiently executed with cauterization rather than with ligature.

Dressings and immobilizing splints are requisites to early rehabilitation. Too often an injured digit is not adequately immobilized. This sets the stage for "autosplinting" by the patient which helps to produce sympathetic stiffness, pain, and muscle spasm. A guide for digital immobilization is to splint an adjacent digit or digits whose active ranges of motion may jeopardize the repair of tendons or nerves or the reduction of fractures and dislocations. For example, the middle, ring, and little finger flexors have a common origin and when any one is injured, they often require splinting to each other.

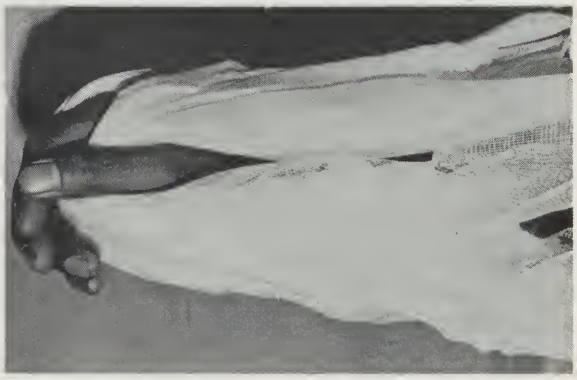


Fig 2: Hand Dressing



Fig 3: Hand Splinting

Interdigital padding, bulky dressings, and plaster splints provide gentle compression and support to prevent edema and reduce pain (Figs 2,3). As a precaution, it is wise to split the dressing or cast to the skin within several hours after the surgery. This release of the circular bandage or plaster is to avoid venous congestion, prevent arterial insufficiency, and to relieve pain secondary to the postoperative edema. This simple maneuver will frequently be rewarding to the physician and patient. It is essential to splint the wrist when immobilizing hand injuries. Wrist positioning is the key to digital attitude. It takes only a moment to think how tired and cramped an injured digit feels dangling at the end of a palmar flexed wrist. Classically, the wrist is immobilized in dorsiflexion of about 20 degrees which permits the fingers to assume a resting arc with the thumb

placed in partial abduction. In recent years, there have been proponents of the so-called intrinsic plus position of the hand (Fig 4).



Fig 4: Intrinsic Plus Position

This places the wrist in slight dorsiflexion, the metacarpophalangeal joints in flexion, and the proximal and distal interphalangeal joints in extension. The thumb is in abduction. This means that the interosseous and lumbrical musculotendinous units assume their maximal length since their function is to flex the metacarpophalangeal and extend the interphalangeal joints. Muscle contractures are often accompanied by capsular joint contractures. The intrinsic plus position is usually favored when contractures are anticipated, such as in the burned or crushed hand.

Now that the hand has received its primary surgical care, what next? Elevation, as mentioned from the very beginning, becomes an integral part of the rehabilitation, since edema itself is restricting and often results in an organizing exudate that produces fibrosis, causing further restriction of motion. Elevation in the hospital is best accomplished by placing the hand and forearm in a bag (Curtis bag or sling), suspended at the side of the bed with the arm resting on a pillow with the hand above the shoulder. Secondary benefits are obtained by maintaining the shoulder in abduction and external rotation. Restricted shoulder motion is not infrequently a post-hand-injury complication, and using the conventional sling or triangular bandage enhances contractures of the shoulder in the undesirable position of adduction and internal rotation. Patients should be encouraged to put shoulders and elbows through a range of motion several times each day during the recovery period. Hospital devices for elevation may not be practical at home. I suggest suspending a pillow case from its open end and inserting the extremity through one cutout corner. Another suggestion is to rest the forearm on top of the head when the patient is ambulatory. When the patient is supine, I advise placing the forearm in a sling and then resting it on a pillow placed on the chest.

The surgeon now relies as much on judgment and experience as he does on scientific skill. He allows for a period of healing prior to referral for therapy. This waiting period is from several days to several weeks. Generally speaking, three weeks of immobilization is sufficient for phalangeal fractures with or without radiographic evidence of callus formation. Metacarpal shaft fractures heal more slowly and may require additional periods of immobilization. Internal fixation utilizing small caliber wires is liberally employed to perform anatomic reductions of hand fractures to allow early active motion (Fig 5).



Fig 5: Internal Fixation

The necessity to anatomically reduce phalangeal fractures is directly related to adjacent joint motion since small degrees of angulation or rotation will upset the flexor-extensor balance. Varying degrees of volar angulation for metacarpal neck fractures is acceptable, depending on the digit. Placing the interphalangeal joints in flexion for a volar angulated fracture of a metacarpal neck is hazardous, since the secondary proximal interphalangeal flexion contracture that often results is more difficult to treat than the fracture itself. One can accept about 45 degrees of volar angulation of the fifth metacarpal neck and retain excellent function. The degree of acceptable angulation diminishes as one approaches the index metacarpal. If there is concern over the amount of angulation of any fracture, internal fixation, which permits early motion of adjacent joints, is favored.

For flexor tendons primarily repaired or grafted, protected passive flexion may be instituted early by the surgeon himself, and then continued by a therapist after the third or fourth week. Most nerve repairs frequently require positioning several joints in excessive flexion to release ten-

sion. Nonanatomic positioning of the wrist and digits in flexion may be necessary for several weeks prior to gradual extension. The amount of flexion and the joints to be immobilized will depend on the amount of nerve gap and level of injury.

With muscle denervation, splints are essential to prevent contractures. For median palsy, the thumb is maintained in an abducted position; in ulnar nerve paralysis, hyperextension of the metacarpophalangeal joints is prevented by blocking the proximal phalanges into flexion; and in radial paralysis, the proximal phalanges and wrist are held in extension.

Extensor tendon repairs at and proximal to the metacarpophalangeal level require placing the wrist in slight dorsiflexion and the metacarpophalangeal joints in full extension. I feel that it is unnecessary to splint the interphalangeal joints, since their prime motion is supplied by the intrinsic (not extrinsic) muscles. This also allows active motion of the proximal interphalangeal joint.

Closed ruptures of the extensor mechanism at the proximal interphalangeal joint (deformity) do well if only the proximal interphalangeal joint is splinted in extension and early active distal interphalangeal flexion is begun by the patient. Closed ruptures of the extensor at the distal interphalangeal joint (mallet finger) require immobilization of the distal interphalangeal joint in slight hyperextension. Caution regarding excessive hyperextension is essential since skin necrosis over the distal interphalangeal joint is a common complication. Lacerations of extensors at a proximal or distal interphalangeal joint level is best explored and sutured primarily.

My first concern with the commencement of any kind of motion, be it active or passive, is not to disrupt the repair or reduction of any structure. For example, a sutured or grafted flexor profundus tendon may be disrupted by active flexion or passive extension. It is while the repair is in its earliest stages of healing that joint motion should be maintained without straining the suture line. Therefore, protecting the digit in flexion and passively flexing the interphalangeal joints is the first step. As time goes on, gentle protected active flexion can begin once there is some passive range. At about six weeks, an attempt is made to passively extend the finger. Early, forced passive extension or hyperextension is hazardous. It is also imperative the hand not be overworked in the early phases of recovery since edema and pain will surely follow. If swelling is produced, the therapy should be stopped and the hand continuously elevated.

I also favor several therapy sessions each week, since the finger joints stiffen rapidly and significant gains in ranges of motion are obtained only in small gradations.

The healing of collagenous structures proceeds for months, so that patients must be cautioned about resuming activity. Declaring a repair healed at the classic six-week interval may mislead a patient and produce an unexpected rupture.

Mobilizing a healing extensor tendon requires placing the part in its relaxed (hyperextended) or protected position and application of gentle passive forces in flexion to loosen the early adhesions before beginning active motion.

It is essential to remember that active ranges of motion are not possible unless one has attained a passive range of motion. Passive motion is not a gargantuan tour de force, but persistent, gentle stretching of contracted or adherent structures. This is aided by using heat which permits the collagen to stretch. Whirlpool, in my opinion, is not for the healed recovering hand, but for open wounds that would benefit from a cleansing bath under supervision. I have found that whirlpool baths place the hand in a dependent position and result in edema.

Intermittent electrical stimulation, I feel, has limitations, since the periods of application compared to the length of time the part is without stimulation is too brief to be of value. Some advocate the use of home stimulators.

Another aid to obtaining motion and reducing edema is the Jobst Intermittent Compression Unit which the patient may use at home. A substitute for the Jobst Unit is the inflatable air splint.

A wide variety of static or directing splints and devices are available to help the patient mobilize stiff joints when he is without supervision (Fig 6).



Fig 6: Hand Rehabilitation Devices

The use of splints is not a substitute for the necessary time-consuming attention of the therapist or surgeon. Recovery is coupled with encouragement and coaching since pain and anxiety play a great role in the anticipated outcome.

Once functional ranges of motion have been approached, grip, grasp, and pinch can be strengthened. It is interesting that there does occur, even with some trivial hand injuries, a cerebral cortical alienation that impedes return of function.

The therapist, in my opinion, is a source of inspiration who demonstrates the progressive changes needed to obtain function.

Problems, such as morning stiffness during recovery, are discouraging to a patient who did so well at the end of "yesterday's treatment." The hand that becomes edematous after overuse or dependency frequently requires a return to methods applied at earlier sessions.

Several parameters help to decide the maximum benefit of the patient's total treatment; the most important is the loss of pain. Diminished pain will be noted as the tissues become more supple, as edema decreases, and ranges of motion increase.

The surgeon must decide with the patient whether further surgery is needed, if function is not as anticipated. Careful evaluation of the existing results, plus other important factors, such as age, handedness, occupation, and general health should again be considered before further surgical treatment.

If the ultimate result is not functional for the patient, the role of rehabilitation becomes expanded since it may now become necessary to retrain the patient.

The ability to function is variable, since the motivation of some patients is astounding, whereas others become totally disabled from a seemingly minor digital accident.

Under the best of conditions, physical methods can do no more than facilitate the results anticipated by the surgeon. Most hand injuries do not require rehabilitation. Injuries which I feel should be referred for therapy and rehabilitation are those which endanger the function of a digit or the entire hand.

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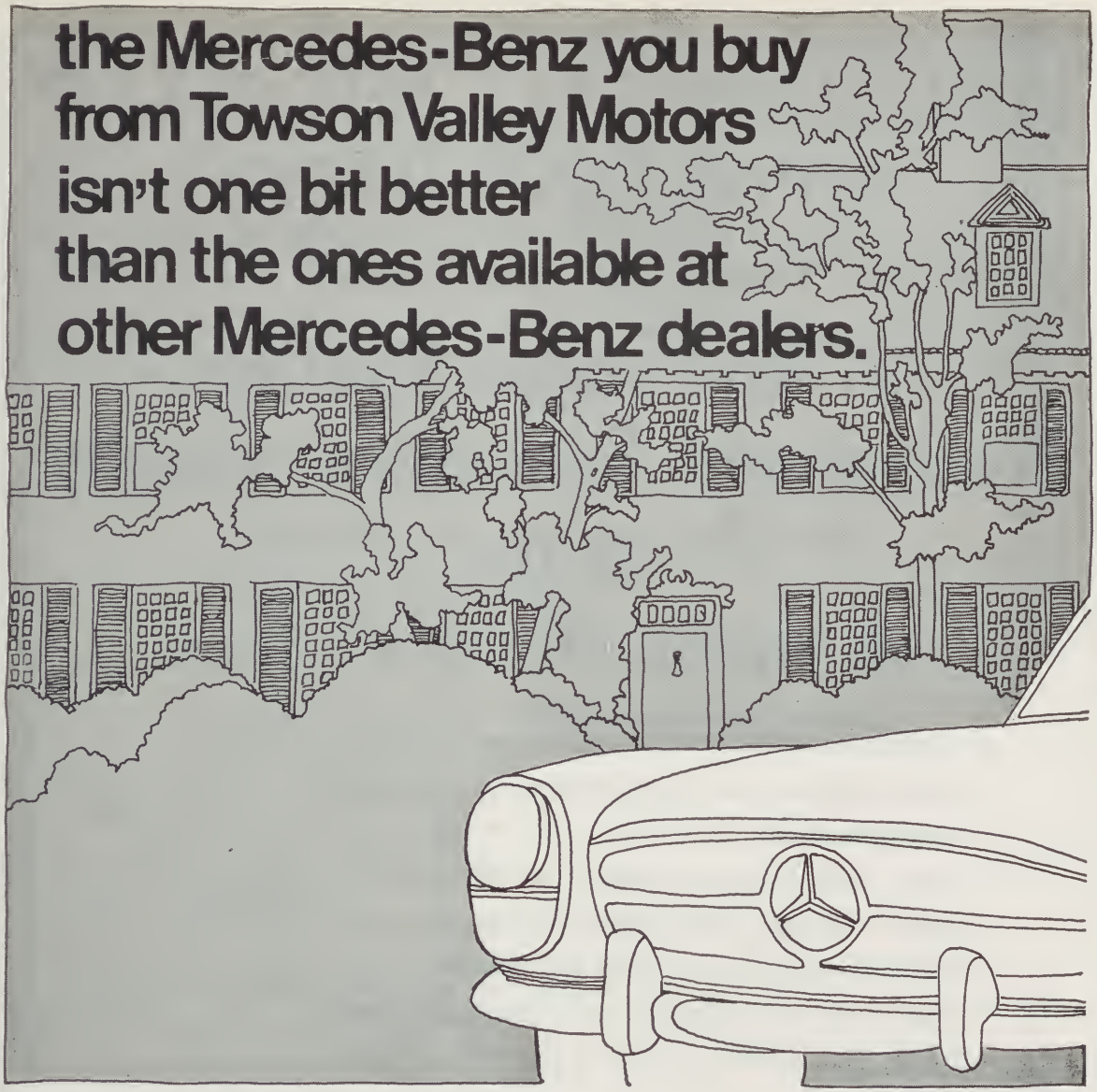
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APRIL 25, 26, 27, 1973

BALTIMORE CIVIC CENTER

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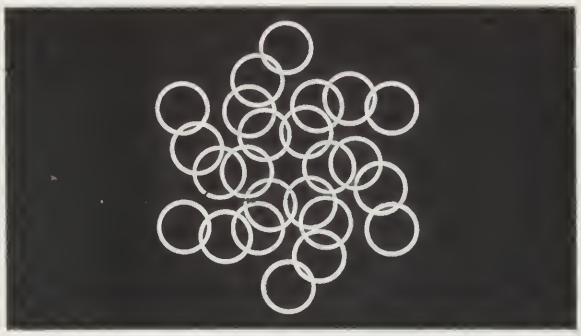
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

# ALCOHOL-RELATED ILLNESSES—PART III

## Alcohol and the Endocrines

The endocrine system is an exquisitely sensitive apparatus, essential to maintain the constancy of the internal environment of the organism. Thus, when a compound such as alcohol, which has characteristics of both a drug and a food and which markedly affects bodily functions, is taken by man, the endocrine system can be expected to react. When such a compound is ingested repeatedly, adaptive changes in the system will occur to maintain the body's internal balance.

The greatest attention to date has been focused on the effects of alcohol on the hypothalamic-pituitary-adrenal (HPA) axis. It was postulated in the late 1940s and early 1950s that preexisting deficiencies in this axis predispose some people to consume alcohol to eventual adrenal exhaustion. Because of certain similarities between Addison's disease and delirium tremens, adrenocortical insufficiency was seen as the end stage of alcoholism. Indeed, with little supporting data, a flurry of essentially uncritical reports appeared, proclaiming the efficacy of adrenocortical extracts in treating the acute stages of alcoholism, including delirium tremens, and in maintaining sobriety. With more careful observation and critical examination of the data, serious questions were raised about the value of indiscriminate use of hormones in the treatment of alcoholic patients.

The effect of alcohol on the HPA axis has been the subject of a recent review. Current studies in both animals and man indicate that alcohol stimulates the adrenal cortex, resulting in the release of its hormones. This stimulation is probably mediated via the pituitary gland, which releases adrenocorticotropic hormone—the hormone that activates the adrenal cortex. Various defects in the HPA axis and metabolism of adrenal hormones in alcoholic persons have been described. There are few consistent findings, however, and any comparison between the HPA status of control subjects and alcoholic patients is complicated by many uncontrolled variables; these include organ pathology and disease states, nutrition, drugs (both illicit and prescription), stress, and emotional factors. There is no convincing evidence that abnormalities in the HPA system are causally related to alcoholism, rather that being associated with or consequences of prolonged alcohol abuse.

Data are accumulating which suggest that alcohol affects the metabolism of another adrenal hormone, aldosterone, which induces retention of sodium, potassium, and chloride. Other hormones that are known to be influenced by alcohol are the catecholamines, such as epinephrine (adrenalin), norepinephrine, and dopamine. Animal and clinical studies indicate that acute administration of alcohol increases the excretion of catecholamines. The metabolism of catecholamines and serotonin has also been shown to be affected by alcohol.

The powerful effect of alcohol on urinary excretion is an old observation, confirmed by experiments. The effects of alcohol on water balance occur partly through the inhibition of the antidiuretic hormone by the posterior pituitary, thus facilitating water excretion by the kidney.

The release of oxytocin, a hormone which stimulates contraction of the uterus, from the

*Reprinted with permission from "First Special Report to the US Congress on Alcohol and Health From the Secretary of Health Education and Welfare," December 1971, DHEW Publication No. (HSM) 72-909).*

*This is the final in a series of three articles originally published in Chapter Four, ALCOHOL AND HEALTH, an authoritative and up-to-date examination of the social and medical dimensions of alcoholism. You may purchase this booklet from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402 — Price $1.50, Stock No. 1724-0193.*

posterior pituitary is also inhibited by the administration of alcohol.

In men, the clinical triad of alcoholic liver cirrhosis, testicular atrophy, and enlargement of the breast is called the Silvestrini-Corda syndrome. Unfortunately, the notion that high estrogen levels affect the endocrine organs of alcoholic persons with cirrhosis has not been convincingly demonstrated. Since the liver inactivates estrogen, the female hormone, it was supposed that the imbalance of gonadal function observed in these alcoholic patients was secondary to cirrhosis of the liver. In an extensive study of cirrhotics suffering from gynecomastia, testicular atrophy, and loss of potency, Lloyd and Williams found low levels of certain sex hormones. In a recent study, Brown reported that the recovery of injected estrogens in alcoholic persons with cirrhosis was within the normal range. Furthermore, quantities and ratios of estrogens in these patients were normal during the preterminal state. The endocrine mechanism underlying the sexual dysfunction in some alcoholic patients still remains an open question.

Information on the effects of alcohol on the other endocrine systems is either scanty and impressionistic, or totally lacking. Thus, while alcoholic hypoglycemia (low blood sugar) is a well-recognized clinical entity, little or no information is available on the role of insulin and glucagon in this phenomenon.

While there have been some clinical assessments to support the observation of hypothroidism in alcoholic persons, this theory is currently under investigation.

### Alcohol and Nutrition

Malnutrition is commonly observed among alcoholic persons. In recent years this has been more true of those found on skid row, but it is by no means rare among those in better circumstances. One of the main reasons for this is the fact that alcohol itself represents an important source of calories. Each gram of alcohol provides 7.1 calories, which means that a pint of 100-US-proof distilled spirits represents more than 1,300 calories, possibly half to twothirds of the normal daily caloric requirement of many people. Therefore, heavy drinkers need less food to fulfill their caloric needs. Since alcoholic beverages do not contain significant amounts of protein, vitamins, minerals, and amino acids, they provide only "empty calories," and the intake of the vital elements of nutrition by a heavy drinker may readily become borderline or insufficient. Economic factors may also reduce the consumption of nutrient-rich food by the alcoholic person.

In addition, even in a person consuming a good diet, heavy alcohol intake can result in malnutrition by interfering with the normal processes of food digestion and absorption. As a consequence, there is inadequate digestion of the food actually consumed. Some of the side effects of gastritis also reduce appetite, thereby lessening food intake. Moreover, alcohol appears to affect the capacity of the intestine to absorb various nutrients, including vitamins—especially vitamins $B_1$ and $B_{12}$ and amino acids. In addition, malnutrition itself further reduces the capacity of the intestine to absorb nutrients.

Some of the important diseases associated with defective nutrition in alcoholic persons have already been noted in the sections of this chapter dealing with the alcoholic encephalopathies, liver, and heart. Others long known to afflict these individuals are polyneuropathy (associated chiefly with deficiency of vitamin $B_1$); pellagra, due to deficiency of niacin and other fractions of the vitamin B complex, with symptoms of dermatosis, digestive disorder, and mental dysfunction; anemia, due to deficiency of iron and cobalamin (vitamin $B_{12}$); and, less often, scurvy, due to deficiency of Vitamin C; and other hypovitaminoses which result in defective bodily functioning of the organism.

In addition, an adequate supply of nutrients, especially protein and vitamins, is needed for the normal maintenance of liver function. The role that protein deficiency may play in the development of liver disease in adult humans has not been clarified. In experimental animals, however, severe protein deficiency has been shown to aggravate the pathological effects on tissues of an alcoholized diet.

One of the significant recent findings concerning the development of injury from alcohol has been the observation that, although nutritional deficiency states can aggravate the effect of alcohol upon the liver, sufficient alcohol—even in the absence of malnutrition—can have a deleterious effect upon that organ.

A particularly dramatic complication of alcohol intoxication is low blood sugar (hypoglycemia) which, if unrecognized, may be responsible for some of the "unexplained" sudden deaths observed in acutely intoxicated alcoholic patients. This complication occurs in individuals whose liver glycogen stores are depleted by fasting or starvation, or in those who have preexisting abnormalities of carbohydrate metabolism.

### Interaction of Alcohol and Other Drugs

In light of the current interest in drug abuse generally, and the particular emphasis being accorded the problems of alcohol as the most

commonly abuse drug, it is pertinent to consider the status of the interrelationships of the use of alcohol in combination with other drugs. An interaction between alcohol and other drugs may contribute to fatal automobile accidents and accidental or suicidal deaths in individuals who have consumed barbiturates or tranquilizers while they were intoxicated. Indeed, more alcoholic persons die from intoxication by drugs other than alcohol, than from alcohol intoxication. Moreover, both alcohol intoxication and alcoholism may affect the dosage requirements and safety limits of medically indicated drugs—for example, anesthetics in surgery, oral medications for diabetes, anticonvulsants in epilepsy, and anticoagulants after heart attacks.

The interaction of alcohol and drugs appears paradoxical. While intoxicated, individuals are more sensitive to many drugs—for example, sedatives and tranquilizers. When sober, alcoholic persons are unusually tolerant to many drugs. In the past, these interactions have been explained as due to the additive actions of drugs and alcohol and by adaptation of the brain to increasing amounts of the drugs.

### Drug Metabolism in the Liver

Alcohol bears many similarities to other drugs that are metabolized by the liver. The prolonged use of such drugs, exemplified by phenobarbital, leads to acceleration of the metabolism not only of the administered drug but also of many others. A single dose of one drug decreases the metabolism of others by competing for the same detoxification mechanism.

In rats fed an adequate diet, prolonged administration of alcohol results in an increased rate of elimination of other drugs in the liver. Studies in human volunteers maintained with adequate nutrients and vitamins showed essentially the same response to the administration of alcohol—namely, an increase in the capacity of liver tissue to metabolize drugs. These findings suggest that the increased rate of drug metabolism in patients who are hospitalized for the treatment of alcoholism is a consequence of their prolonged heavy alcohol intake rather than of nutritional factors or the intake of other drugs.

The similarity of alcohol to other drugs has also been found to be true in studies of inhibition of drug metabolism. Alcohol intoxication in both rats and men conspicuously delayed the elimination of phenobarbital and meprobamate from the blood; that is, it inhibited drug metabolism. An explanation for the similarity of alcohol to other drugs metabolized by the liver was the finding that alcohol is partially metabolized in the liver by a system similar to that which metabolizes other drugs.

In summary, alcohol is one of the drugs metabolized by the liver. A single large dose of alcohol leads to the inhibition of the metabolism of other drugs, while prolonged heavy intake leads to accelerated drug metabolism. These findings on the combined effects of alcohol and drugs explain, in part, the accentuated tolerance of alcohol persons, when sober, to other drugs, as well as the enhanced effect of other drugs in persons intoxicated by alcohol.

### Drugs and the Central Nervous System

On the behavioral level, many other drugs when used simultaneously with alcohol are capable of grossly distorting the usual responses expected from alcohol consumption alone. This is due to the combined effects exerted by alcohol and other drugs on the central nervous system.

The interactive result of taking alcohol and other drugs that also depress the central nervous system may be either additive or potentiative (sometimes called synergistic). An additive effect is experienced when a half-dose of one drug taken with a half-dose of another similarly acting drug produce the same effect as a full dose of either drug alone. A potentiative effect results when half-doses of two drugs taken together produce an exaggerated action that is grossly disproportionate to the effect of a full dose of either drug taken separately. An example of a potentiative effect is the combination of barbiturates and alcohol which produces a depressant effect on the central nervous system that is much greater than would occur from either of these drugs taken alone.

During the past several decades, hundreds of new drugs have been produced and introduced to the public. Their judicious use by physicians has revolutionized the practice of medicine, affording great relief from suffering and saving countless lives. Many of these drugs are legally obtained only through medical prescription. Others are freely available on drug store, supermarket, and specialty-shop counters.

Some of these drugs are central nervous system depressants, acting on the same brain structures as alcohol. They include drugs for inducing sleep, tranquilization, sedation, and for relief of pain, motion sickness, or head cold and allergy symptoms. The drugs used for these purposes in the United States—both by prescription and for self-medication—are too numerous to name. But they can be classified according to the principal purpose of their use: narcotics; hypnotic-sedative drugs (including barbiturates); tranquilizers; antihistamines; and volatile solvents.

Narcotics are mainly opium, morphine, heroin, codeine, and synthetic drugs such as Demerol

(meperidine hydrochloride) and methadone. Next to alcohol, narcotics have been the most widely abused drugs. The general action of all narcotics on the central nervous system, and their major medical use, is to depress the sensory areas of the cerebral cortex, resulting in relief of pain. The general depressant action of these drugs also includes sedation, apathy, drowsiness, sleep, and—with high enough dosage—respiratory failure and death.

Hypnotic-sedative drugs (including barbiturates) are primarily general central nervous system depressants that exercise a broad range of suppression of brain function. These drugs differ from each other in the degree of depression they produce. Increasing dosages of all hypnotic-sedative drugs, however, produce a continuum of effects, from tranquilization and sedation . . . to motor and intellectual impairment . . . to stupor, coma, and death. This is similar to the progression seen with alcohol.

In the past, hypnotic-sedative drugs such as chloral hydrate, paraldehyde, and bromides were widely used in medicine and by the general public for sedation and inducing sleep. They are often replaced in medicine by the more effecient and easily controlled barbiturates, which can produce the entire range of depressant effects, from mild tranquilization to deep anesthesia. A person under the influence of barbituates acts exactly like one under the influence of alcohol. Depending on the dose, his speech is thick and slurred; he sways; he staggers; he falls; he loses consciousness. As explained previously, alcohol and barbiturates when combined enhance each other's effects. The consumption of even small amounts of both drugs in close order can be particularly dangerous and may result in death.

Tranquilizers are drugs used mainly to relieve or prevent uncomfortable emotional feeling, reduce tension and apprehension, and promote a state of calm and relaxation. The effects overlap with those of depressant drugs such as alcohol. Some sedative and hypnotic effects from tranquilizers are similar to those of barbiturates which, in turn, have tranquilizing actions.

Tranquilizing drugs vary widely in potency. If used without medical direction the stronger tranquilizer drugs such as Compazine (prochlorperazine) and Thorazine (chlorpromazine), can be dangerous even in low dosages, with effects ranging from marked depression to deep sleep. The weaker tranquilizers such as Miltown (meprobamate), Valium (diazepam), and Librium (chlordiazepoxide) are considerably less severe in their effects. Because the effect of tranquilizers combined with alcohol may be potentiative, patients for whom they are prescribed should be instructed about the heightened danger of their drinking and particularly about the increased risks in operating motor vehicles or machinery.

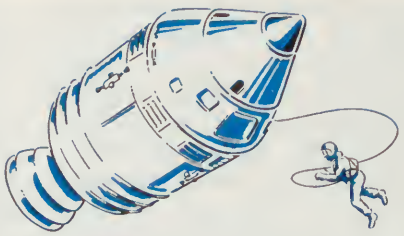
Antihistamines block the action of histamine in the body. Histamine is a substance produced in the body under certain pathological conditions such as head colds and allergies, and is responsible for the congestion, bronchial spasm, and unpleasant tissue inflammations characteristic of these conditions. Antihistamines prevent or relieve these symptoms. The drugs in this group are numerous, and include Dramamine (dimenhydrinate), Benadryl (diphenhydramine hydrochloride), Phenergan (promethazine hydrochloride), and Pyribenzamine (tripelennamine). Some of the antihistamine drugs also have the ability to diminish or abolish the symptoms of motion sickness, and many drugs marketed for this purpose contain moderate to large doses of antihistamines. The antihistamines are included among the hypnotic-sedative drugs because they act as central nervous system depressants. In ordinary dosages they cause drowsiness. Larger amounts produce sleep. Because of their depressant action, these drugs are the major ingredients in most of the nostrums advertised as "tension" relievers and sleep-inducers, and are freely dispensed without prescription. Their potential additiveness with alcohol often goes unrecognized.

Volatile solvents include compounds of volatile substances such as isoamyl acetate, ethyl acetate, toluene, methanol, and many others, which are additive or potentiative with alcohol. As such, these compounds have a depressant effect on the central nervous system similar to barbiturates and narcotics. Apart from a small population of "glue-sniffers," there are large numbers of people who are exposed for many hours to inhalation of these vapors in industrial situations. Intoxication due to the interaction of such exposure to drugs and a relatively small amount of alcohol has frequently been reported, especially in the courts, when an intoxicated driver was a victim of this interaction phenomenon.

The use of any drug that has a depressant effect on the central nervous system in combination with alcohol represents an extra hazard to health and safety and, in some cases, to life itself.

**References**

A complete listing of the references used with this article may be secured from Mr. Ludwig L. Lankford, Division of Alcoholism Control, 2305 N Charles St, Baltimore, Md 21218, or from Alcohol and Health. Information and reprint requests should also be directed to Mr. Lankford.



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*– George Sarton, from "The History of Medicine Versus the History of Art"*

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

# Opinion

**Results of a questionnaire to 7,000 physicians:**

**62.9%**
**Believe combination drug products are useful.**

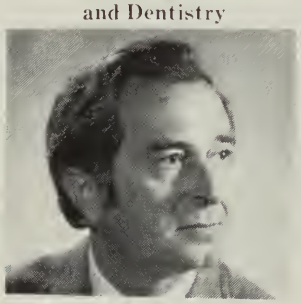
**13.8%**
**Do not believe combination drug products are useful.**

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

## Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

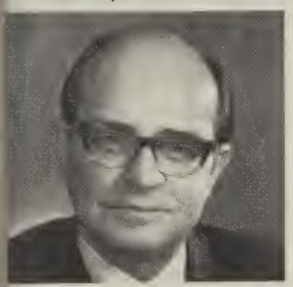
The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years and that have an apparent satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin - streptomycin combinations that patients—especially surgical patients—were given in oil injection. This made for less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such a preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the proper use) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.

# Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" deries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the *usual* dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

**What is your opinion, doctor?**
**We would welcome your comments.**

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**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treat[illegible]ias (including agra[illegible] and c[illegible] and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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VOLUME 21 NOVEMBER 1972 NUMBER 11


**ARTICLES:**


**Three Deliveries that Changed the History of the World—**
Louis M. Hellman, MD ..... **41**

**A Functional Respiratory Care Service—**
Martin I. Gold, MD ..... **49**


**SEMIANNUAL REPORTS TO THE HOUSE OF DELEGATES:**


**Bylaws Committee** ..... **70**

**Delegates to the AMA House of Delegates** ..... **70**

**Reference Committee** ..... **72**

**Minutes, Semiannual Session** ..... **74**


**DEPARTMENTS:**


**Your Medical Faculty at Work**—John Sargeant ..... **6**

**Maryland Medical Political Action Committee** ..... **17**

**Baltimore City Health Department—Alcoholism Center; Immunization Status Report** ..... **22**

**Woman's Auxiliary—Semiannual Meeting Highlights** ..... **24**

**Occupational and Environmental Health News—The Private Practitioner and the Working Man—**
Herman J. Halperin, MD ..... **25**

**Rehabilitation Medicine—Rehabilitation of Patients with Chronic Diseases**—Douglas Carroll, MD ..... **28**

**Heart Page—A Practical Approach to Extrasystoles—**
Robert R. Montgomery, MD ..... **64**

**Alcoholism Section—The Person Inside the Alcoholic—**
Anthony Reading, MD ..... **67**

**Library—Nineteenth Century Medicine in America; New Accessions** ..... **86**

**Maryland State Department of Health and Mental Hygiene—Local Health Services**—J. Howard Beard, MD; Charles M. Yost ..... **92**

**Emergency Medical Services—An Ounce of Prevention—**
Harvey B. Snyder, MD ..... **94**



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**MISCELLANY:**


New Council Members **8**
Innoculations Regulations **9**
Doctors Take Note **10**
Doctors in the News **11**
Hospital Salute **13**
Medical Miscellany **13, 27, 93**
Director's Newsletter **19**
Book Reviews **34**
Semiannual Meeting **35**
Annual Meeting **36, 85**
Open Forum **54**
VD Treatment Schedule **54**
Sports Seminar **56**
Scientific Exhibits **78**
Info for Authors **98**
Classified Advertising **99**
Advertising Index **100**

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*Warnings:* Use during pregnancy is to be avoided.

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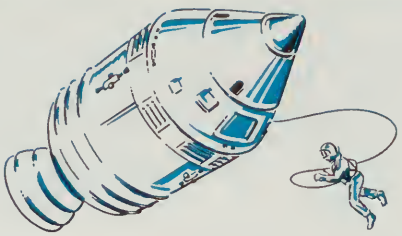
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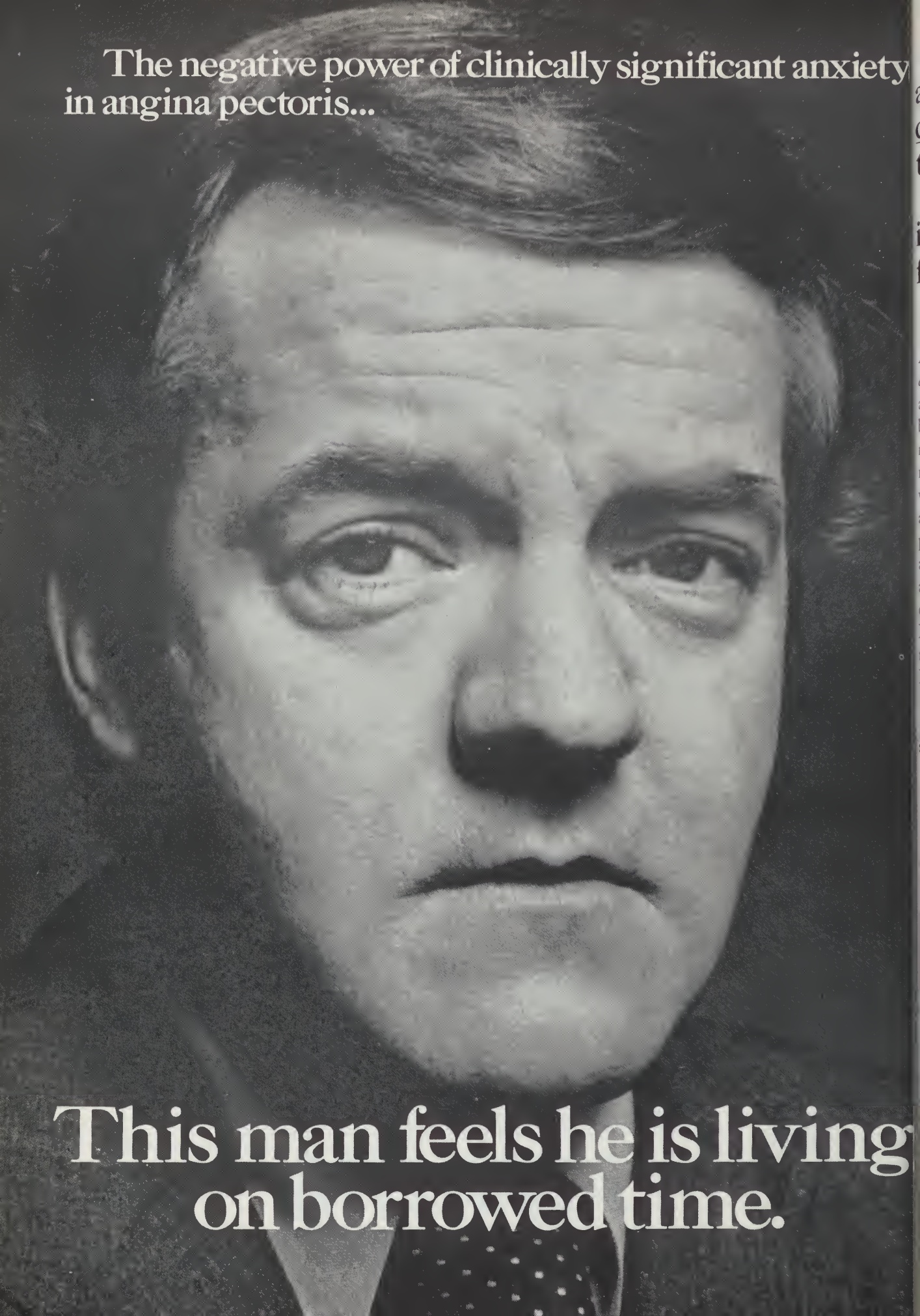
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The negative power of clinically significant anxiety in angina pectoris...
This man feels he is living on borrowed time.

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# Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

*Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable* for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

*Librium (chlordiazepoxide HCl) is used concomitantly* with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

## The positive power of adjunctive Librium® (chlordiazepoxide HCl)

**10-mg, 25-mg capsules up to 100 mg daily**

## for moderate to severe anxiety accompanying angina pectoris

**Before prescribing, please consult complete product information, a summary of which follows:**

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**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

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**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

**A copy of the Levine study may be obtained from your Roche representative.**

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# your medical faculty at work

**by John Sargeant,**
**Executive Director**

**The House of Delegates of the Faculty met in semiannual session in Ocean City, Md, on Friday, Sept 15, 1972 at the Ocean City Convention Hall and took the following actions:**

1. Elected the following as directors of the Maryland Foundation for Health Care:

| | |
|---|---|
| Arthur E. Cocco, MD, Baltimore | 1974 |
| Katherine H. Borkovich, MD, Baltimore | 1975 |
| Earl C. Clay Jr., MD, Columbia | 1973 |
| Clifford L. Culp, MD, Annapolis | 1975 |
| John R. Davis, MD, Baltimore | 1974 |
| Leeds E. Katzen, MD, Baltimore | 1973 |
| Watson P. Kime, MD, Baltimore | 1973 |
| Harry F. Klinefelter, MD, Baltimore | 1974 |
| Edward J. Kowalewski, MD, Baltimore | 1975 |
| Charles H. Ligon, MD, Sandy Spring | 1974 |
| Alan C. Woods, MD, Baltimore | 1974 |
| Manning W. Alden, MD, Annapolis | 1973 |

2. There being no objection, the President declared he would name the only nominee from the floor, W. Kenneth Cruze, MD, of Montgomery County, as one of the six presidential appointees to this Board.

3. Adopted a Bylaws change that would give representation in the House of Delegates without vote to students at both Maryland medical schools. Representation would be on the basis of two from each school, one to be chosen from the Junior Class and one to be chosen from the Senior Class. The method of selection would be determined by the students themselves.

4. Adopted the auditor's statement for the 1971 financial year of the Faculty.

5. Adopted the following resolution on recommendation of the Reference Committee:

WHEREAS, On April 15, 1897, there did meet at the Grange Hall, Towson, Maryland, 18 physicians then practicing the noble art of medicine in Baltimore County; and

WHEREAS, They did proceed with energy, dispatch and concord to devise a working constitution, adopt it, alert officers and establish the time and place of the next meeting; and

WHEREAS, Soon thereafter, 45 physicians did confirm these actions by affixing their signatures to said constitution; and

WHEREAS, This association, named the Baltimore County Medical Association, has maintained its existence and its purposes to this day, altered only by the prudence of incorporation in 1952; and

WHEREAS, Baltimore County Medical Association, Inc., has achieved a lusty, vital and active 75 years of age; therefore, be it

*Resolved,* That this Assembly notes these achievements, encourages the extension of its plans and congratulates it on its longevity; and be it further

*Resolved,* That this resolution with its enclosed addenda, a facsimile of the original meeting notes and signatures of the 45 original Committee members, be made part of the minutes of the House of Delegates session, Friday, Sept 15, 1972.

*(The facsimile is attached only to the House of Delegates minutes contained in the minute book held at the Faculty Office.)*

**The Council met on Thursday, Sept 14, 1972 at Ocean City, Md and took these actions:**

1. Reconsidered previous action in connection with proposed regulations involving immunization of persons at high risk and determined that the action of the June 8 Council session would stand as adopted.
2. Authorized cooperation with the *Baltimore News-American* in publication of a Sunday supplement dealing with the medical profession and the Faculty in particular. It appropriated funds for coordination of the data and material to be developed in this connection.
3. Authorized employment of a Public Relations Consultant for the calender year of 1973, with funds for this purpose to be taken from the Educational Fund.
4. Reappointed C. Thomas Flotte, MD, as editor of the *Maryland State Medical Journal* for an additional three-year term.
5. Recommended Emeritus Membership to the House of Delegates for various persons on request of the component societies involved.
6. Renamed John F. King, Esq., as legal counsel for an additional one-year term.
7. Established 1973 meeting dates for Council sessions.
8. Adopted a suggested assignment form, as recommended by the Medicolegal Committee, for use by physicians when treating or evaluating patients at the request of attorneys in cases under litigation.
9. Received a statistical report on the Health Evaluation Tests conducted during the 1972 Annual Session.
10. Approved the concept that primary payment for auto accident victims be by health care payment systems rather than through automobile insurance. This request was made by the National Blue Cross Association.
11. Heard a progress report from the Blue Cross Utilization Review Task Force reparding a pilot project currently under way in six hospitals in Maryland, dealing with lengths of stay.
12. Approved employment of legal counsel to determine legality of the Social Security Administration issuing directives to fiscal intermediaries requiring that only 40% of any fee increase be recognized for Medicare patients.
13. Approved payment of partial expenses ($100) for attendance of a subcommittee chairman at a national conference in Chicago.
14. Adopted a position to oppose any changes in the current statute dealing with drug substitution.
15. Received a progress report in connection with the purchase of land in Howard County for a possible new building location.
16. Tabled a request for $1,000 to cover printing costs of a component medical society's history.
17. Received information that the Public Service Commission concept will probably be implemented for hospitals and their costs within the next 12 months. When this occurs physicians employed by hospitals, either on a salary or percentage arrangement, will have such arrangements open to public scrutiny.
18. Authorized the Public Relations Committee to develop a press conference in connection with the Medicaid Task Force Study group and the Faculty's long-standing recommendations for improvement in the Medicaid program.
19. Heard a plea from the Council chairman for the profession to show a united front to the public and government, inasmuch as actions of specialty societies might indicate a "divide and conquer" tactic.
20. Heard the President indicate that a meeting of component society presidents has been scheduled for Jan 11, 1973, and that he would invite specialty society presidents to attend this same session. Its purpose deals with attempting to receive advice and assistance as to how best to serve the membership.

# MEET YOUR NEW COUNCIL MEMBERS

This month the series on new Council members spotlights Katherine H. Borkovich, MD, who assumed the office of second vice president of the Faculty at the conclusion of the Annual Meeting on May 5, 1972.

Dr. Borkovich and another woman physician, Carolyn H. Pincock, MD (see September Journal), are the first women in Med-Chi history to serve on the Council.

Dr. Borkovich is a Board-Certified Internist specializing in Cardiology. She is affiliated with the Johns Hopkins Medical Institutions as an associate professor of medicine and has been in private practice at 550 North Broadway since 1961 and in Baltimore since 1944.

A Diplomate of the American Board of Internal Medicine, she is an active participant in medical society affairs. She has served as president and as secretary-treasurer of the Maryland Society of Internal Medicine, as well as on the national body of that group.

Dr. Borkovich also has staff privileges at these Baltimore hospitals: Union Memorial, Good Samaritan, and Church Home and Hospital.

She is a Fellow of the American College of Physicians. The Med-Chi Peer Review, Mediation, and Policy and Planning Committees number her as a member.

Dr. Borkovich has also served in various offices of the Baltimore City Medical Society and the Maryland Heart Association. (She is currently vice president of the City Society.)

She is presently serving as president of the Johns Hopkins Women's Medical Alumnae Association, and also served in a similar capacity from 1955 to 1957.

She was the elected medical staff representative to the Medical Board of the Johns Hopkins Hospital for three terms for a total of seven years between 1961 and 1971 (longer than any male, she claims!).

Alpha Omega Alpha, an honorary medical society, numbers her as a member. And her alma mater, Geneva College, awarded her its Distinguished Service Award in 1960.

She is also a member of the Blue Cross Physicians' Panel, and Maryland Blue Shield's Utilization Review Subcommittee.

And she also serves as Medical Advisor to the Bureau of Hearings and Appeal - SSA DHEW.

Dr. Borkovich is the author of several articles on primary pulmonary hyptertension, remediable hypertension, and complications of anticoagulant therapy.

A 1939 grad of the Johns Hopkins University School of Medicine, she took her postgraduate training at the Pittsburgh Medical Center and at the Johns Hopkins Hospital.

In 1963 she had the honor of serving as a foreign service officer with the US Information Agency Medical Exhibit in Yugoslavia.

In extra-curricular activities, football and baseball command her spectator interest. But, when it comes to travel, she is an active participant. Faraway places, mountains, and mountain-climbing hold a special attraction for her.

A world traveler, she has been to South and Central America, including Guatemala, Honduras, Mexico, and the Yucatan. She has journeyed to South and East Africa and Europe three times.



**Dr. Borkovich**

Her latest trip — one certainly filled with adventure— was to the antarctic this past February. On the way north from the antarctic circle and the antarctic continent, the ship on which her group was traveling was grounded in Admiralty Bay, King George Island, some 600 miles south of Cape Horn.

After several harrowing hours in the open sea in a 70-mph snow blizzard they were rescued by a Chilean naval vessel and taken to Punta Arenas, Chile, from whence she made her way back to Baltimore.

But this near mishap has not deterred her from planning yet another trip on the same vessel, the Lindbad Explorer, this time to China in June and July of 1973.

So, in addition to charting new courses as the first woman Council member (together with Dr. Pincock), she will continue to chart new courses to faraway places in remote corners of the world.

# SCHOOL INNOCULATIONS REGULATIONS ISSUED

To protect Maryland's children from serious complications that can result from childhood diseases, Neil Solomon, MD, Secretary of Health and Mental Hygiene, has signed regulations requiring nursery, kindergarten, and first grade children to have six immunizations in order to attend school. The regulations take effect Jan 1, 1973.

Diphtheria, pertussis (whooping cough), tetanus, rubeola (measles), and rubella (German measles) vaccines will be required, as well as oral polio vaccine.

In signing the regulations, Dr. Solomon noted that voluntary immunization programs have been held for several years in Maryland, but that the new regulations will ensure that Maryland children receive all the immunizations they need.

"After careful study of every aspect of requiring these immunizations," Dr. Solomon said, "I have determined that this protection for our children is necessary; however, I have insisted the regulations contain the provision that physicians may withhold the use of any vaccine in particular cases where it is not in the best interest."

His decision to include rubella vaccine among those required for school attendance, despite opposition from a small medical group, was based on the fact that it had been declared safe by the Federal Food and Drug Administration and the Bureau of Biological Standards, DHEW. The determination to include rubella was also made on the fact that more than 33 million doses of the serum had been given throughout the United States and that out of this total number only a very small fractional percentage of those receiving the vaccine had any arthritic after effects, and these were transitory.

The list of highly influential endorsing organizations which have approved the use of rubella vaccine is long and impressive, and includes the Maryland Medical and Chirurgical Faculty, the American Academy of Pediatrics, the Immunization Advisory Council of the US Public Health Service, and the National Foundation.

The secretary also said that Maryland is one of 29 states which have made rubella immunization a requirement, and that 13 other states now have its mandatory use under consideration.

Dr. Solomon advises all women of child-bearing age to have a blood test to determine whether or not they have had rubella, and are therefore immune to rubella infection. This test is routinely performed in the department's prenatal and family planning clinics.

The regulations also provide that the six immunizations be given to children in the second through sixth grade of school, beginning in the fall of 1973.

Where parents cannot obtain the services of a private physician or clinic, the vaccines will be provided by the local health department.

The complete official notice follows.

**Maryland State Department of Health and Mental Hygiene 10.02.20**
**Regulations Governing Required Immunizations Prior to Entry Into a Maryland School**

Pursuant to the authority conferred by Article 77, Section 84, of the Annotated Code of Maryland, 1971 Replacement Volume, 1972 Supplement, the following regulations governing required immunizations prior to entry into a Maryland school are hereby established.

**.01 GENERAL**

No school principal or other person in charge of a school shall knowingly admit any pupil to or retain any pupil in a public or private nursery, kindergarten, or elementary school who has not furnished evidence of primary immunizations against diphtheria, tetanus, pertussis, poliomyelitis, measles (rubeola), and rubella (German Measles) in a manner approved by the Local Deputy State Health Officer. Such immunization will be in accordance with the current schedule of immunizations recommended by the Maryland Steering Committee on Immunization Practices of the Medical and Chirurgical Faculty of Maryland. Exception may be made for a period of 90 days in the case of a child whose parent or guardian indicates that his child is in the process of complying with these regulations and furnishes evidence of further compliance after the start of the school term or within a reasonable length of time that is consistent with the current schedule of immunizations.

**.02 MEDICAL CONTRAINDICATIONS**

These regulations shall not apply to any pupil who presents a written statement from a licensed physician or a Local Deputy State Health Officer indicating that immunization against any or all of the above mentioned diseases is considered medically contraindicated, detrimental to, or not in the best interest of the child's health. The statement shall indicate whether the contraindication is permanent or temporary. If temporary, the statement shall provide assurance that the child will receive the immunization (s) and furnish evidence of their completion.

**.03 RELIGIOUS CONFLICT**

Any parent or guardian who presents a written statement of objection to immunizations upon the grounds that they conflict with the tenets or practices of a recognized church or religious denomination of which he is a member, shall not be required to present a physician's certificate of immunization. This exception will not apply in case of an emergency or epidemic of disease which is declared by the Secretary of Health and Mental Hygiene.

**.04 VACCINE PROVISION**

If for any reason a parent or guardian is not able to obtain the service of a private physician, he may take his child to the local Health Department where such immunizations will be provided.

**.05 RESPONSIBLE AGENCIES**

Responsibility for carrying out the provisions of these regulations is delegated jointly to the local Superintendents of Schools, the Local Deputy Health Officers, and the Commissioner of Health, Baltimore City.

**.06 EFFECTIVE DATE**

The effective date of these regulations shall be Jan 1, 1973, for all children in nursery, kindergarten, and the first grade; Sept 1, 1973, for all children in the second through the sixth grades.

Adopted Date Aug 18, 1972 Effective Date Jan 1, 1973

# Doctors take note...

## MARYLAND AREA MEETINGS

| | | |
|---|---|---|
| Nov | 8-10 | **In-Vitro Studies in Nuclear Medicine,** Johns Hopkins Med Institutions, Baltimore. Director: HN Wagner MD. Contact: ACP, 4200 Pine St, Philadelphia Pa 19104. |
| Nov | 13-16 | **Interstate Postgrad Med Assoc of North America,** 57th Anl Scientific Assembly, Washington-Hilton Hotel, Washington DC. Primarily for family physiclans & internists. $25 fee, 26 hrs instr. Contact: Alton Ochsner MD, IPMA, PO Box 5445, Madison Wisc 53705. |
| Dec | 2 | **6th Anl Medical Aspects of Sports Seminar.** Sponsors: Med-Chi & Catonsville Community College, Baltimore. |
| Apr | 25-27 | **Med-Chi 175th Anl Mtg,** Civic Center, Baltimore. |

## AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

| | | |
|---|---|---|
| Jan | 8-10 | **Three Days of Liver Disease,** Emory Univ School of Med, Royal Coach Motel, Atlanta. 21 hrs cr. |
| Dec | 4-8 | **Advances in Diagnosis & Treatment in Clinical Medicine,** Univ Calif, Los Angeles, Disneyland Hotel, Anaheim. |

## MISCELLANEOUS MEETINGS

| | | |
|---|---|---|
| Nov | 17-18 | **Postgrad Crs on Knee,** Col of Medicine of NJ, Newark. Contact: AE Foley, NJ Med School, 100 Bergen St, Newark NJ 07103. |
| Nov | 24-25 | **Conf on Radiology in Otolaryngology & Ophthalmology,** Chicago. Sponsor: Abraham Lincoln Sch of Med, Univ of Illinois Med Cen. Contact: GE Valvassori MD, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680. |
| Nov | 29-30 | **3d Anl Symposium for Emergency Dept Personnel,** Cherry Hill Inn, Cherry Hill NJ. Sponsors: NJ Chaptr ACEP & NJ Trauma Comm of ACS. Regis fee $40. Contact: HH Butler MD, Underwood-Memorial Hosp, Woodbury NJ 08096. |
| Dec | 2-7 | **Amer Acad of Dermatology,** 31st Anl Mtg, Americana Hotel, Bal Harbour Fla. Contact: AAD, 2250 Northwest Flanders St, Portland Ore 97210. |
| Dec | 5-7 | **American Assoc for Comprehensive Health Planning,** 2nd anl mtg, San Diego Calif. Conf theme: Health Planning at the Crossroads—Time for Decisions. Contact: AACHP, 801 N Fairfax, Alexandria Va 22313. |
| Dec | 4-7 | **Louisiana Thoracic Society,** 9th anl postgrad crs for drs on Pulmonary Function in Health & Disease, New Orleans. Contact: Louisiana Thoracic Society, 305 Baronne St, New Orleans La 70112. |
| Dec | 8-9 | **American Rheumatism Assoc Section of Arthritis Foundation,** scientific mtg, Pittsburgh Hilton Hotel, Pittsburgh. Contact: Lynn Bonfiglio, ARAS, Arthritis Foundation, 1212 Ave of the Americas, New York NY 10036. |
| Dec | 10-13 | **Assoc of Military Surgeons of the US,** 79th Anl Conv, San Antonio. Contact: Off of Info, Aerospace Med Div, Air Force Systems Command, Brooks Air Force Base Texas. |

# Doctors in the News

**Louis J. Pratt Jr.,** MD, Baltimore County pediatrician, has the honor of being appointed as the first football team physician for the new Loch Raven Senior High School in Baltimore County.

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After 50 years of service to the medical profession, including 45 years as a surgeon at the Easton Memorial Hospital, **William D. Noble,** MD, of Easton, has retired.

His accomplishments and impact were summed up in testimonials in the Talbot County press.

"He impressed all of us with his industry, economy, honesty, and kindness," said William P. Chalfinch, president of the hospital's board of directors. "His virtues will never be improved upon by those able physicians who follow in his footsteps," he added, in comments typical of those quoted.

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**Dr. Robert I. Bosman** has been appointed chief, Division of Certification and Field Services of the Department of Health and Mental Hygiene's Laboratories and Research Administration.

He has assumed responsibility for inspection, surveillance, and licensing of all independent and hospital clinical laboratories in Maryland.

Dr. Bosman retired from the Army Medical Corps last March after a career of 30 years.

He is certified in clinical pathology and pathologic anatomy by the American Board of Pathology.

**Recep Ari,** MD, Chevy Chase, has been granted Fellowship in the American College of Cardiology (ACC), the national medical society for specialists in cardiovascular diseases.

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At the recent annual meeting of the Maryland Chapter of the American College of Radiology, the following officers, all MDs, were elected:

**John S. Green,** president

**Saylord Knox,** vice president

**George Burke,** secretary

**Robert Hirschfeld,** treasurer

**David Golub, John Hearn,** counselors

**Gaylord Know, Henry Lewis,** alternate counselors

**Ryun Kim, Robert Perilla,** board of directors

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**David B. Skinner,** MD, has been appointed chairman and the Dallas B. Phemister professor in the Department of Surgery at the University of Chicago.

Dr. Skinner had been professor of surgery at the Johns Hopkins School of Medicine and a surgeon on the attending staff of the Johns Hopkins Hospital.

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Washington College, Chestertown, has announced the appointment of **John A. Wagner,** MD, to its Board of Visitors and Governors.

Dr. Wagner is professor of neuropathology at the University of Maryland School of Medicine and a distinguished alumnus of Washington College.

Seven faculty members at the University of Maryland School of Medicine were promoted to full professor effective July 1.

**Eugene S. Bereston,** MD, became professor of medicine. He has been a member of the department of dermatology since 1946 and is chief of dermatology at Mercy Hospital.

**B. Stanley Cohen,** MD, is now clinical professor of rehabilitation medicine. Dr. Cohen has been with the university since 1967 as clinical associate professor of physical medicine and rehabilitation.

**Albert F. Heck,** MD, became neurology professor. Dr. Heck has been affiliated with the university through much of his medical career, both as a student and faculty member.

**James Roscoe Karns,** MD, was promoted to professor of clinical medicine. An alumnus of their medical and pharmacy schools, he took his internship and residency at the University of Maryland Hospital.

**Curtis L. Meinert,** MD, became professor of preventive medicine. Dr. Meinert has served as deputy director of the division of clinical investigation since its creation in 1965.

**Joseph S. McLaughlin,** MD, was promoted to professor of surgery. Also head of the division of thoracic and cardiovascular surgery, he joined the medical school faculty in 1965 and was named associate professor in 1970.

**Morton I. Rapoport,** MD, was promoted to professor of medicine. Dr. Rapoport is also associate coordinator for the Maryland Regional Medical Program at the university and chief of medical service at the Loch Raven VA Hospital.

**John M. Krager,** MD, MPH, assistant health officer in the Baltimore County Department of Health, has been reelected to a three-year term as chairman of the Maryland State School Health Council, an advisory group to the State Department of Education and the State Department of Health and Mental Hygiene.

The Council is a multidisciplinary body consisting of one representative from each local health department and department of education, and an executive board from 12 Maryland organizations.

Other physician members—all MDs—and the county health department represented are:

**Elmer L. Hill,** Allegany

**Julius Loebl,** Anne Arundel

**William Pope,** Garrett

**Robert Hinckley,** Montgomery

**Aurora F. Alberti,** Prince George's

**Mary P. Warner,** Washington

**John Saratsiotis,** Baltimore City

Other physicians on the Council include **Robert Dawson,** MD, representing the Maryland Chapter, American Academy of Pediatrics; **Margaret L. Sherrard,** MD, the Med-Chi representative; and **Alice Tobler,** MD, for the Maryland State Department of Health and Mental Hygiene.

Formed 25 years ago, the Council assists the secretary of health and mental hygiene and the state superintendent of schools in the development of school health programs which afford maximum health benefits to all school children in Maryland.

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The first distinguished service award of the American College of Preventive Medicine has been presented to **Ernest L. Stebbins,** MD, dean emeritus of the Johns Hopkins University School of Public Health.

Dr. Stebbins received the award and an honorarium for his achievements in preventive medicine, contributions to education, and leadership in founding the American Board of Preventive Medicine.

Dr. Stebbins is professor emeritus of public health administration and international health, and was dean of the School of Public Health from 1946 to 1967.

The award was made in San Francisco at a joint meeting of the Association of Teachers of Preventive Medicine and the AMA's section on preventive medicine.

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**Bernard Tabatznik,** MD, has assumed his new duties as director of medical education, director of the postgraduate institute, and coordinator of ambulatory services for the North Charles General Hospital in Baltimore. He had served as chief of the department of cardiology since 1970.

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**Irvin H. Cohen,** MD, director of residency training, Sheppard and Enoch Pratt Hospital, Towson, has been elected president of the Maryland Psychiatric Society.

**John B. Imboden,** MD, chief of psychiatry at Sinai Hospital, Baltimore, is the new president-elect.

The secretary-treasurer is **Thomas Lynch,** MD, acting medical director, Seton Psychiatric Institute, Baltimore.

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**Romualdo R. Dator,** MD, has been appointed director of the recently-completed Surgical Shock-Trauma and Surgical Intensive Care Units at Baltimore's St. Agnes Hospital.

In assuming this new full-time surgical post, Dr. Dator is responsible for the organization, development, and operation of the surgical shock-trauma and surgical intensive care units. He is also responsible for the professional education for the resident staff.

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## Med-Chi Salutes

# NATIONAL INSTITUTES OF HEALTH

The Clinical Center of the National Institutes of Health Public Health Service, Department of Health, Education and Welfare, located in Bethesda, Md is a 14-story, 516-bed research hospital with 1,100 laboratories. It is designed to bring scientists into close proximity with clinicians caring for patients, so that bench investigators and physicians may collaborate on problems of mutual concern.

Patients are selected—after referral by their physicians—solely because they have a precise stage of an illness needed in a particular study being conducted by one or more of the Institutes. The illnesses under study at the Clinical Center have always been those which are all too common in people throughout the nation.

The educational programs offered at the Clinical Center include two-year associateships, work-study programs for senior medical students and nurses, guest lecturers, and a graduate program of evening courses offered by the Foundation for Advanced Education in the Sciences, Inc.

The Clinical Center houses the NIH Library and is near the National Library of Medicine which is located on the NIH campus.

The hospital is located in Montgomery County, just outside Washington, DC, and is directed by Thomas C. Chalmers, MD.

## Breast Cancer Being Studied

The cooperation of physicians is requested in the referral of patients with breast cancer for studies being conducted by the National Cancer Institute's Medical Breast Unit at the Clinical Center, NIH, Bethesda, Md.

Following primary breast surgery, a segment of this patient population has been identified as being at high risk of early relapse. These are patients with resectable lesions and positive axillary nodes by histopathology.

Of particular interest are patients in the early postoperative period for consideration in long-term chemotherapy studies to eliminate microscopic foci of disease. Patients must have no known evidence of metastatic disease and must have either four or more positive nodes, or at least one positive high axillary node, or primary tumors greater than 5 cm in diameter.

Hospitalization pertaining to the patient's breast cancer will be accomplished at NIH. General medical care will be continued at the referring facility which will receive follow-up notes subsequent to each patient visit to the Clinical Center.

Physicians interested in having their patients considered for these studies may write or telephone Douglass C. Tormey, MD, Clinical Center, Room 6-B-15, National Institutes of Health, Bethesda, Md 20014, Phone 301-496-6375.

## Tranquilizer Study

The effectiveness of two minor tranquilizers (benzodiazepines) in treating anxiety and hostility is being evaluated in a study conducted by Carlos Azcarate, MD, instructor in psychiatry at the University of Maryland School of Medicine.

For the study, Dr. Azcarate is seeking patients who often experience anxiety, hostility, anger, or episodes of irritable, impulsive, or violent behavior.

Persons with these problems can be considered for participation in the study by means of referral from area physicians and hospitals. A referral may be made by calling for an appointment at 528-6475.

Anyone who is considered psychotic is unsuitable for the program. While participating in the study, patients are required to avoid the use of any medication which affects the central nervous system.

After taking some uncomplicated psychological screening tests, the patient is given a physical examination and lab tests and interviewed by Dr. Azcarate. On this initial visit, the patient is given one of the two drugs to be evaluated, but neither he nor the doctor will know which one until the study has been completed.

After the patient has been on a daily dosage of the drug for two weeks, he is again interviewed and psychological tests performed. At the third and final appointment, the patient receives another physical and lab tests and is offered further treatment or given appropriate referral.

All services provided during the four-week study will be free of charge.

# Medical Miscellany

## University of Maryland Preceptorship Program

The Family Practice Program at the University of Maryland School of Medicine has been notified that it will receive a special grant for preceptorship training. This grant is to enable full-time undergraduate students to receive part of their education under a preceptor in family practice, pediatrics, or internal medicine in rural or other areas having a severe shortage of physicians.

These preceptorships should enable the student to gain insight into a medical way of life of a family physician in private practice in a community, and to demonstrate what family practice is, the varied scope of the family physician's work, and the diverse problems encountered.

The preceptorship experience will serve to clarify for the student the physician's place in society, his social and civic obligations and his responsibilities to his patients. Thus, the student may more fully grasp the true nature of private practice and the need to understand each patient in relationship to his family, his job, and his total environment.

The preceptorship provides a brief period away from the medical school setting during which the student can develop mature ideas concerning his own values and goals. Observation of the practicing physician in his working environment affords the student an opportunity to develop a true perspective of the patient-physician relationship. It also permits the student to participate almost totally in a "medical way of life" with a dedicated physician carefully selected by the medical school.

A preceptorship program ideally should be an integral part of the Medical School curriculum. Even though the medical student may not plan to enter family practice, he should have a basic understanding of the nature of this specialty and its relationship with other branches of medicine.

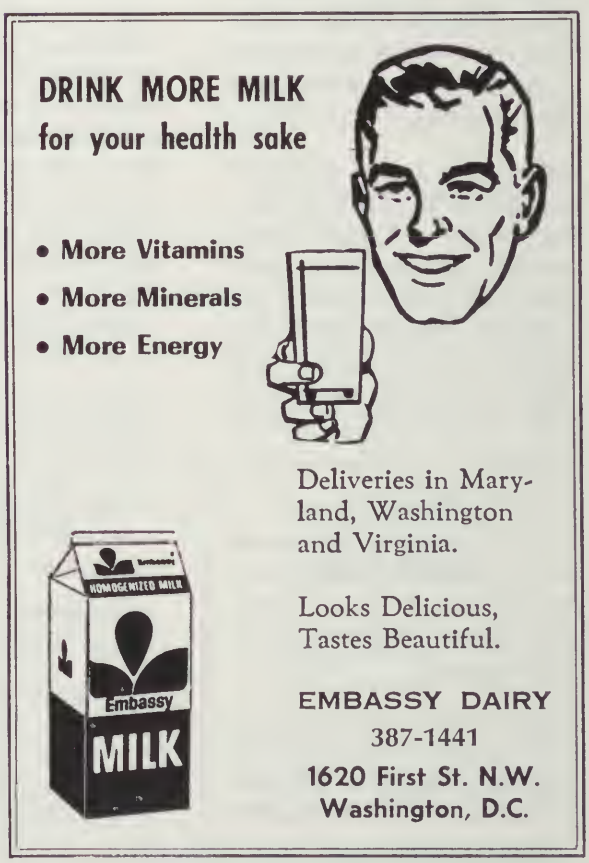
The administration of our program at the University of Maryland will be by the Family Practice Program, and will include preceptorships located in the inner city, in rural communities, and participation in the Model Family Practice Unit of the Division of Family Practice at the University of Maryland School of Medicine.

Preceptors who devote time and energy to the education of medical students recognize that this sacrifice is necessary to encourage students to make a career choice of primary medical care. Preceptorship programs are the most effective means we have available to introduce the student to the community and thus offer it for his consideration as a place to practice.

For this effort, preceptors can expect recognition by faculty appointments at the Medical School as they demonstrate their interest in medical education and by their efforts to solve the shortage of primary physicians throughout the state.

As a result of this grant, all individuals and organizations who have made contributions to sponsor preceptorships, such as the Maryland Academy of Family Physicians, the Student Council of the University of Maryland, the Baltimore City Medical Society, the Prince Georges County Medical Society, and others will not be solicited in the near future to continue financial support. But concerned members of these organizations will be asked to act as preceptors for students who are interested in observing medical practice "out there where it is."

J. ROY GUYTHER, MD
Associate Professor
Family Practice Program

## Clinical Center Studies Noted

The cooperation of physicians is requested in the referral of patients with primary or secondary amenorrhea, or oligomenorrhea for studies being conducted by the National Institute of Child Health and Human Development's Reproduction Research Branch at the Clinical Center, NIH, Bethesda, Md.

Selected patients in the following categories will be admitted for diagnosis, treatment, or both:

1) Primary or secondary amenorrhea. Ovulation induction will be done in appropriate patients interested in conceiving.

2) Oligomenorrhea with intermenstrual intervals of 35-45 days. Anovulatory or infertile patients referred for ovulation induction in this category should have undergone appropriate studies to rule out organic pelvic disease.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having patients considered for these studies may write or telephone Judith Vaitukaitis, MD, or Griff T. Ross, MD, Clinical Center, Room 10-B-09, National Institutes of Health, Bethesda, Md 20014, Phone 301-496-4686 or 301-496-6974.

## Sinai Begins Rehab Service

A new rehabilitation medicine bed service for inpatients has been established at Sinai Hospital of Baltimore, giving the hospital a comprehensive rehabilitation institute. According to a hospital spokesman, it is the only program of its kind in Maryland under the direction of full-time specialists in rehabilitation medicine.

B. Stanley Cohen, MD, chief, Department of Rehabilitation Medicine, calls the move essential. He says it provides hospitalized patients with a team of skilled specialists who "can help them on the road to reaching their highest levels of function."

Patients who are eligible for the service are those who have ended their medical or surgical care, but need a hospital environment to help them adjust to their disability. The primary consideration in all cases is that the patient have the potential to achieve physical, social, psychological, or vocational rehabilitation and that a hospital setting is necessary.

The patient's stay is made as short as possible. During that period he is encouraged to be self reliant, that is, to dress himself in outer clothing rather than pajamas; to go unescorted to therapy appointments where possible; and to eat meals in a department dining area rather than at bedside.

When the patient is discharged, he is returned to the care of his primary physician. Rehabilitation follow-up is carried out by the department.

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In my way of thinking, no matter how you explain it or disguise it with scientific jargon, the cure for alcoholism is readily available to all. I believe that the things which are so impossible with men are possible with God.

R. M. Mayfield—LISTEN

## Student Aid for Future Doctors

The Robert Wood Johnson Foundation has announced a four-year $10 million student-aid program to increase the number of future doctors likely to enter practice in medically underserved areas.

All of the nation's 108 schools of medicine will receive four-year grants for use as scholarships and loan awards to women students, students from rural backgrounds, and those from the country's black, Indian, Mexican-American, and US mainland Puerto Rican populations.

David E. Rogers, MD, president of the Foundation, said that plan to focus the grants on these groups of students was based on two main consideration: 1) evidence indicating that student physicians with such background characteristics are the most likely to choose practice locations in underserved areas, and 2) the decision by the Foundation to concentrate on the improvement of access to personal health services as one of its principal goals.

The Foundation was established in 1936 by the late General Robert Wood Johnson, who died in 1968, leaving the Foundation the bulk of his estate.

This bequest was received by the Foundation in 1971, bringing its year-end assets to approximately $1.2 billion, and marking its change from a local institution to a national health foundation.

Details have been furnished the deans of all of the US schools of medicine.

## Health Problem Sound Familiar?

Do these national health problems sound familiar?

- Low standards in some hospitals and medical centers.
- Lagging quality and lag in number of medical services in rural areas.
- Slow construction of hospitals and other health service buildings.
- Continued pollution of air, water and soil by industrial wastes and inadequate use of money allotted to purification systems.

Familiar, maybe, but actually these complaints were listed by the Soviet Government in Pravda, the Communist party newspaper.

To ease their health crisis the Russians plan to open 31 major clinics with 1,000 or more beds between 1971 and 1975, says the Health Insurance Institute. Seventy other specialized hospitals and medical centers are also planned.

Particular emphasis is being placed on improving medical care for rural communities.

## List 4 Reasons Marcus Welby Has Real Edge

There are four basic reasons why television's Dr. Marcus Welby has a clear-cut advantage over his real-life colleagues.

Reports one authority (Dr. John Hirschboeck, coordinator of Wisconsin Regional Medical Programs): "Forty million people watch Dr. Welby every week and think he's their idea of a good physician."

He explains:

"What they don't realize is that he:

"1) Handles only one patient a week.

"2) Has a handsome and helpful young assistant.

"3) Can devote complete hospital facilities to his one patient.

"4) No one ever gets a bill."

According to the Health Insurance Institute, the average physician is more likely to:

"1) Handle about three patients an hour.

"2) Considers himself lucky if there's even a homely assistant nearby.

"3) Is relying more on out-of-hospital care than ever before.

"4) If his patients didn't pay their bills, he would probably have to turn in his shingle for a job as a technical consultant on a television doctor show."

## Health Service Internal Controls

The health care delivery system is on short notice to demonstrate effective internal controls over the quality and costs of its services, or to be prepared to live with an externally imposed and bureaucratically administered control system.

In response, the revised standards of the Joint Commission on Accreditation of Hospitals mandate that hospital boards, administration, and organized medical staffs implement programs to assure the quality and cost effectiveness of all care rendered for both inpatients and outpatients.

The Joint Commission and its parent organizations—the American College of Physicians and of Surgeons, the AMA, and the AHA—believe that the quality assurances demanded by the standards will be effective in satisfying demands of the consumer movement and its political supporters for public accountability. The standards present a system in which control of the quality remains professional, local, and internal to the hospital, while still functioning in the context of the public accountability insisted upon by the consumer movement.

The TAP Institutes (Trustees, Administrators, Physicians) sponsored by the Joint Commission, translate these quality requirements into practical, realistic hospital credentialing and medical audit systems. They will advise key medical staff, administrative, and board personnel in how to conduct and document an internal quality assurance program that will, by conforming to the standards, qualify a hospital to become or to remain accredited and at the same time satisfy the broad policy demands of the public.

At issue is not only the accreditation status of the individual hospital, but also the future direction that the entire voluntary health care delivery system will take.

The current TAP Institute schedule follows:

December 2-3, Watertown, Me; April 14-16, Homestead, Va; May 4-6, Ocean City, Md; and May 11-13, Lake of the Ozarks, Mo.

•

Every time a person takes a few drinks he hastens the process of brain cell loss, damaging his brain by cutting off oxygen supply to enormous numbers of small areas of brain tissue, thereby killing large numbers of brain cells prematurely.




**RAYMOND L. MARKLEY, MD, Chairman**

**MRS. FRANCIS C. MAYLE, Editor**

# YEAR OF DECISION

William H. Cooper, MD, was the speaker at the MMPAC Luncheon at the Semiannual Meeting in Ocean City. Dr. Cooper practices obstetrics and gynecology in the District of Columbia and is a member of the AMPAC Board of Trustees.

In a talk entitled "Year of Decision" Dr. Cooper emphasized that the election this November is an unsual one in many respects and one in which AMPAC efforts must be more effective than ever. The presidential race between President Nixon and Senator McGovern has resulted in a polarization of the electorate much greater than in any recent election. Considerable money is being diverted to the presidential race because of the strong feelings many people have for either one or the other candidate. On the other hand, almost all of the very large sums of money available to COPE will be spent on the congressional races. Therefore, the money which PAC can contribute to congressional candidates is more important than ever before.

The Federal Election Campaign Act which was enacted in April has considerably complicated the work of the state PAC treasurers. Fortunately, as the law is now being interpreted, it does not apply to PAC support of candidates for state offices. However, accurate records must still be submitted for all monies contributed to candidates for federal office. The new law has had the advantage of making many state PACs more efficient. Candidate support is now a matter of public record, and PACs are considering somewhat more carefully the disposition of their funds.

Dr. Cooper mentioned a number of facts which are important to remember. All 435 members of the House of Representatives are up for election, and in almost every case they are running in a new or changed district because almost every district has been changed at least to some extent. Candidates running in districts with which they are not familiar need help from PAC more than ever. For a variety of reasons 41 Congressmen and six Senators are not seeking reelection. These figures represent 10% of the House and 6% of the Senate. On the other hand, 10% of Congress has already been elected because of candidates running without opposition. Obviously a considerable change in the complexion of Congress is in the making.

It is encouraging that AMPAC membership is up 20% over the country. PAC membership is now the largest it has ever been, and Dr. Cooper expressed the hope that membership would continue to grow at an accelerating rate.

National AMPAC headquarters never initiates support for any candidate. Candidate support must originate with the state PAC. In September when Dr. Cooper spoke state PACs were involved in 185 nonpartisan Congressional races in important swing districts. Candidate support committees had been established in many cases. These committees can be one of the candidate's best assets, and are particularly effective when they involve interested and active doctors' wives. The wives of doctors in many state PACs are among the most valuable members. In other cases, for differing reasons, the candidate will accept contributions from PAC, but would rather not have a candidate-support committee which might make him appear to be medicine's candidate. State PACs always allow candidates to make their own decisions in such matters.

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# executive director's newsletter

November 1972

**TO ASSOCIATE MEMBERS**

Associate Members of the Faculty are eligible for appointment to various Faculty committees. Interested persons should request a copy of the Faculty Bylaws for the purpose of ascertaining the charges and responsibilities of the various committees. They should then direct their request to the Faculty President - De Witt E. De Lawter, MD.

**GLOSSARY OF TERMS**

Many physicians are nonplussed when faced with various terms such as HMO, AMA-ERF, etc. Herewith is a glossary for easy reference of some of those most commonly used:

HMO - Health Maintenance Organization
PSRO - Professional Services Review Organization
AMA-ERF - American Medical Association, Education and Research Foundation
MMPAC - Maryland Medical Political Action Committee
AMPAC - American Medical Political Action Committee
PA - Professional Association
PRO - Professional Review Organization

In some cases individuals are not clear as to what is meant by certain phrases. Herewith a handy explanation:

Fee for Service - A manner of practice of medicine, based on remuneration in accordance with the individual service rendered.

Title 19 - That portion of the Social Security law dealing with provision of health care to persons with low or no income, commonly known as Medicaid.

Title 18 - That portion of the Social Security law establishing the Medicare system of health benefits for persons over age 65.

Peer Review - An examination of a physician's practices by other physicians. The term is generic, inasmuch as it would apply as well to an examination of nursing practices by nurses, dental practices by dentists, etc.

If there are any other terms with which individual physicians are not familiar, please let us know so we can acquaint all members with their meaning.

DISPOSAL OF USED HYPODERMICS

Complaints are being received by the Faculty office through police officials and other authorities that juveniles and addicts are obtaining used hypodermic syringes from trash disposed of by physicians.

All are urged to adequately destroy needles and syringes so as to ensure they cannot be reused. Your cooperation in this matter will assist greatly in reducing the number of complaints received in this regard.

PROPOSED REGULATIONS ON METHADONE AND AMPHETAMINES

In accordance with House Bill 89, adopted by the 1972 General Assembly, the Faculty and Department of Health and Mental Hygiene have developed regulations governing the prescribing of Methadone and Amphetamines by physicians.

Copies of these draft regulations may be obtained through the the Faculty office. They do not become official until advertised and formally adopted by the Department.

DELEGATION OF DUTIES BY PHYSICIANS

The Board of Medical Examiners is currently developing regulations dealing with the Delegation of Duties by Physicians, in accordance with legislation to take effect on Jan 1, 1973.

Suggestions for inclusion in the regulations are solicited by the Board and should be submitted promptly.

John Sargeant

Executive Director

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ROBERT E. FARBER, MD, MPH, Commissioner

Baltimore City health department

## ALCOHOLISM CENTER ASSISTS ARMED FORCES

The Baltimore City Health Department Alcoholism Center is assisting the Armed Forces in training military personnel who will be assigned to organize and staff hospital or special units for the rehabilitation of alcoholic servicemen.

Five Navy and six Army personnel are enrolled in the Alcoholism Counselor Training Program. These men are taking the usual six-month program except for a modification of the last phase of training. Their program consists of two months of classroom instruction, two months' field work in local general hospitals, and two months in designated military hospitals in nearby areas.

Prior to the last phase of training, the Alcoholism Center's training staff will assist the designated hospitals in setting up alcoholism rehabilitation programs as part of their ongoing hospital operation so that newly trained military personnel will have a functioning unit in which to further their practical experience. Upon termination of training, the men will be assigned to various military establishments where they will help develop new alcoholism training and rehabilitation programs.

The Armed Forces' work in the rehabilitation of alcoholics in the service is not particularly new, but interest has accelerated as a result of the enactment in September 1971 of Public Law 92-129. Title V of the law stipulates that the Secretary of Defense shall develop programs for the identification and treatment of drug and alcohol dependent persons in the Armed Forces.

The men now in the training program have been assembled from stations in the United States and abroad. Some of them are housed at Reed Hall through special arrangements with the Johns Hopkins School of Hygiene and Public Health.

Funded in its entirety by a grant from the National Institute of Alcohol Abuse and Alcoholism, the city's Alcoholism Counselor Training Program was begun September 1967. Because of its uniqueness and accomplishments, the program has achieved national prominence and plans are being considered at the federal level for establishing a national alcoholism training program in Baltimore City.

The Alcoholism Training Program has its headquarters at 2221 St. Paul St in the health department's Alcoholism Center. The program is directed by A.M. Schneidmuhl, MD, and Mrs. Gladys Augustus.

## IMMUNIZATION STATUS REPORT

An "Immunization Status Report" received from Mr. Anthony Zipp, chairman of the City Health Department's Immunization Committee, indicates a successful chapter in Baltimore's mass immunization program to protect children against polio, measles, and rubella.

In the recent school-neighborhood mop-up immunization program conducted for children one year old through grade three, the record shows 22,544 children protected against measles, 18,454 immunized against polio, and 4,576 vaccinated against rubella.

Taking these figures into account, the overall picture of Baltimore's current immunization status for protected children one through nine years old is as follows: against polio—128,338 or 87% of the target group of 148,223 children; against measles—141,549 or 95%; and against rubella—120,366 or 81%. The record to date is one which reflects creditably on the city, its parents, the medical profession, the school personnel who assisted the hard working inoculation teams, and the cooperating federal, state, and local agencies.




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MRS. ROBERT A. REITER, Editor

woman's auxiliary

# HIGHLIGHTS FROM THE SEMIANNUAL MEETING

Fun as well as work was the order of the day as Med-Chi's Semiannual Meeting—Sept 14, 15, 16, — convened at Ocean City, Md, amidst ideal beach weather. Castle in the Sand proved an excellent choice for headquarters since it was just across the way from Ocean City's new convention hall. This convention hall had wonderfully roomy parking areas, which alone were enough to make it an ideal meeting place, but it also had satisfactory meeting rooms.

The pleasant glass-walled promenade in front of the meeting rooms held the registration desks, Mrs. Sanford's display of new library books, the travel bureau desk, and the AMAERF stand where, among other things, chances were available for the 1973 Semiannual Meeting to be held in Mexico City. Winner of the drawing will receive a five-day, expense-paid (air fare, hotel, two daily meals) trip for two to Mexico City, Sept 19-23, 1973. All proceeds from the draw will go to the AMA Education and Research Foundation and the funds will be designated for equal distribution between the Maryland and Johns Hopkins medical schools.

On Friday, Sept 15, President Mrs. Marvin L. Kolkin called the Auxiliary meeting to order at 10:00 AM with a quorum of delegates and many members present. Paul A. Mullan, MD, gave greetings from the Med-Chi Faculty and, among other things, urged Auxiliary support for "Action '72." He expressed concern about the continued lowering of the image of the medical man, quoting Senator Kennedy's remark "that doctors used to be healers but now they are business men," and suggested we try to find ways of improving the image.

Convention Chairman Mrs. Dewitt DeLawter reported that the Annual Meeting will be held April 26, 1973 at the Holiday Inn in downtown Baltimore. In place of the inadequate rooms given us in a previous convention there, the management has assured her of ample accommodations on the eighth floor.

Mrs. Martin Strobel was elected to serve as chairman of the Nominating Committee. The four members elected to serve with her represented Allegany, Baltimore City, Harford, and Montgomery Counties, which was considered a fair distribution.

At the national convention in June, the Maryland Auxiliary received three national awards for outstanding work for AMAERF. These three awards, which were certificates of achievements, were presented to the winning counties by Med-Chi President, Dewitt DeLawter, MD. He then presented state certificates of achievement to the four counties who had contributed the largest amounts to AMAERF. State certificates were also awarded in three categories: largest amount per capita, greatest percent increase, and Project Christmas Cards. After the presentation, a rising vote of thanks was given Mrs. Elmer G. Linhardt for her highly successful work with AMAERF.

Following announcements by the President and resumés of county projects by the county presidents, the meeting adjourned at 12 noon. Mrs. Francis C. Mayle, chairman of legislation, held a legislative workshop at 2:00 PM. Attending were the legislative chairmen from each of the counties. Since the national presidential election occurs before the Auxiliary's regularly scheduled workshop sessions, it was necessary for Mrs. Mayle to meet with her committee at this time.

Wicomico County Auxiliary received the thanks and appreciation of all the members for the lovely floral decoration they contributed.

The day ended on a light and happy note. The Annual Dinner, with doctors and their wives and guests in attendance, was held at Convention Hall. The after-dinner entertainer was a magician whose feats of legerdemain were strictly those of this electronics age. We hope Dr. Kolkin survived the cherry cordial pulled out of the air by the wizard!

**occupational and environmental health news**

EDITORS:
James Frenkil, MD
Donald J. Roop, MD
Robert Brandt, MD
Carlos Villafana, MD, Chairman
Walter E. Fleischer, MD
Herman J. Halperin, MD
William J. McClafferty, MD

# The Private Practitioner and the Working Man

HERMAN J. HALPERIN, MD

*Information and reprint requests to Dr. Halperin at 1211 Cathedral St, Baltimore, Md 21201.*

Industry has grown to such a degree that it constantly affects the lives of masses of people—not alone in economic terms, but also in terms of their physical well-being. Better food products, better housing, better recreational facilities, improvement of hygienic conditions, the increase and scope of better medical care, have all contributed to the increase in the standard of living. However, this growth has also created a new environment whose workers are exposed to all types of physical and mental hazards, to newly developed toxic materials and their by-products, and to increasing social and economic stresses.

The company and the working man in it cannot survive if good health is not maintained. It is common knowledge that there is a direct relationship between health and efficiency. The employer must recognize that the worker is a complete individual with a home, family, and financial concerns. The worker also has problems related to other workers and to his supervisor. The employer may bear the brunt of a host of manifestations even though these are initiated in the family situation. When the employee leaves for work, he doesn't leave his aches and pains, his frustrations, his emotional problems at home, nor does he dump them into the lap of the watchman at the front gate.

When an industry is large and supports a complete medical department with physicians, nurses, and paramedical personnel, the detection of illness becomes comparatively easy. But when there is no medical department, the worker has to rely on his fellow worker, his family, and his family physician, to detect the development of a symptomatology which will give rise to some sort of a diagnosis, be it occupational or non-occupational in origin.

An unhappy marriage, for whatever cause, problems with children, parents, siblings and other relatives, financial worries of all types, problems with friends and companions, people in general, personal and other health problems, whether they are physical or mental, contribute in a large part to non-productivity. Watch for anxiety, depression, and excessive fears, progressing to belligerent hostility, indecisiveness, disloyalty, irresponsibility, apathy, and general emotional instability.

The employee with a drinking problem is a problem not only to himself, but to his family, his physician, his employer, and to society. Signs and symptoms of alcoholism are many and varied, but there usually is a set pattern. There are repeated absences, usually on Mondays or Fridays or following pay day. He presents such excuses as death in the family and/or financial problems. He then reports to his family physician who covers for him by issuing a certificate with diagnoses such as nervousness, grippe, bronchitis, gastroenteritis, and diarrhea. The physician should alert himself to puffiness of the face and eyes with deepening creases at the corners of the eyes, redness of the eyes and nose, swelling of the membranes of the nose, throat and larynx, leading to huskiness of the voice. Tremor of the hands is also a frequent finding. The alcoholic will often use medicinal lozenges to counteract the strong odor of alcohol on his breath. The physician who shelters such a patient does a disservice to himself, to the patient, and to society.

A worker who takes drugs without prescription (drug abuser) often appeals to his family physician for help and cover up. The physician should be alert to a hyperactive individual with increasing restlessness; tremors of the hands; unclear or slurring speech; panting respirations; sweating; flushed face or paleness; dilated or pinpoint pupils; increasing thirst; loss of ability to think, work and concentrate; staggering gait; lethargy and a tendency to fall asleep easily; running of the nose and eyes with redness of the

eyes; cold, sweaty palms; agitation; loss of coordination; moodiness; depression and panic; loss of judgment and memory; feeling of well-being and hilarity. The addict is a pathologic liar and will lie repeatedly to deceive. He will usually wear long-sleeved shirts to cover obvious needle marks and scars. He will rarely undress completely, to keep the identifying marks from being seen. The addict is sick and needs prompt medical care.

In taking a history from a patient, the physician should inquire into the working and environmental conditions within a plant, factory or office. Working in poorly ventilated plants or offices predisposes to disease and reduces the energy and physical capacity of the worker. Fatigue initiates a slowdown in production and is responsible for many accidents. Important causes of fatigue are mental and physical illness; poor lighting, heating and ventilation; extended work periods, such as numerous overtime periods without sufficient rest intervals; the monotony of repetitive motion and automation; speed; and excessive noise. Improper personal hygiene facilities cause friction, short tempers, and emotional upsets. Proper attention to eating facilities; drinking places; dressing and locker rooms; and bathing, washing, and toilet facilities is mandatory.

The family physician should inquire into the products that are manufactured. He should be aware of the by-products and the possible toxic effects and the signs and symptoms they produce. If an industrial physician is not available for help, then he may contact the occupational disease sections of the city and state health departments. Another agency that is most helpful is the Occupational Health Section of the US Public Health Service. With the passage of the Occupational Health and Safety Act of 1970, family practitioners can play a greater role in identifying health hazards in industry. The physician must also realize that exposure to chemical and other substances is part of modern living and occurs not only in the course of occupations but in the household and in the street.

This paper cannot attempt to list the signs and symptoms occurring in every occupational disease. It will, however, list them according to main body structures:

1) **Skin**—Skin irritations and rashes in industry may be due to substances known as primary irritants. Because of their very nature (acids, alkalis, solvents, etc) they produce a dermatitis in many people who aren't necessarily sensitive. The other type of exposure is to a substance which produces a rash after repeated contact, over a period of time, in a sensitive individual. Look for excessive scratching and scratch marks, redness, blotching, bleeding sores, oozing pus, crusts, changes in fingernails, swelling, excessive sweating, and dryness. Some exposures may produce changes in color, such as cyanosis, excessive flushing, paleness, and icteric tinting. Occasionally, the skin may bronze or take on the color of silver. Look for changes in hair — loss, bald spots, increasing coarseness, and brittleness.

2) **Eyes**—Watch for redness, tearing, blinking, bulging, unequal pupils, excessively pinpoint or wide pupils, discharge, blood spots, and yellowish discoloration. Patients may complain of seeing double or that their vision is getting bad.

3) **Face**—This may be a clue to many conditions. Changes that may occur are drooping of one side of the mouth or eyelid, the inability to sustain a facial expression such as a smile, the dejected look of worry and anxiety, the wide-eyed look of mania, unusual grimacing, unusual swelling and puffiness.

4) **Mouth**—Loss of teeth; staining and discoloration of teeth and gums; ulcers; dryness; swelling and coating of tongue; foul breath or peculiar odors such as garlic, sweet, or fruity; excessive salivation and dribbling of saliva; and bleeding may point to toxic exposures.

5) **Nose**—Ulcers, swelling, redness, paleness, discharge, fetid odor, difficulty in breathing, stuffiness, excessive watery secretions, sniffing, sneezing, bleeding, and perforation of the nasal septum are some of the things to look for.

6) **Ears**—Swelling, redness, loss of hearing, dizziness, ringing, buzzing, discharge, and bleeding are cardinal signs and symptoms.

7) **Throat**—Change in speech, hoarseness, swellings, complaint of pain or swallowing.

8) **Chest**—Dyspnea, labored breathing, wheezing, persistent cough and expectoration, blood in the sputum, and any type of chest pain.

9) **Digestive System**—Loss of appetite and weight, dyspepsia, excessive belching, nausea and vomiting, diarrhea, constipation, abdominal cramps, hematemesis, black or tarry stools, general debility.

10) **Nervous System**—Headaches, lassitude, irritability, giddiness, sleeplessness, tumors, twitchings, dizziness, change or disturbance in gait, weakness or paralysis of muscles or muscle groups, peculiar numbness or tingling, muscle cramps, melancholia, irascibility, depression, shyness, profuse sweating, disorientation, drowsiness, mental confusion, forgetfulness, belligerency, fits of anger and temper, changes in speech, and increasing fatigue out of proportion to the nature of the work.

11) **Miscellaneous**—Your patient may complain that he is passing dark urine and that he has severe low back pain. He may mention that his joints ache, that he has noted his heart beat and pulse quicken, that he bruises easily and has numerous black and blue marks.

The physician should be alert to the malingerer. He constantly feigns illness for his own personal gain, be it economic or social. Malingering is probably a symptom and not a disease. It is believed by some that malingerers are psychologically disturbed, but the nature of their difficulty is not clearly understood. A malingerer may attempt to avoid unpleasant assignment by constantly complaining of aches and pains and feigning illness by simulating disease symptoms and signs. Examples of malingering are simulating deafness to avoid unpleasant work or to escape being penalized or fired, and simulating painful joints to avoid heavy assignments. The malingerer claims inability to work but enjoys ball games, movies, and participation in sports. He is irresponsible and is an occupational migrant. The malingerer refuses work offered which could be done without involving the part of the body allegedly disabled.

Health counseling services are urgently needed, especially by private practitioners where there are no inplant medical departments. Illness can be reduced considerably if disease is detected in its early stages before damage to the body becomes permanent. Today, the clinician and the pathologist are able to perform a system of multiphasic screening techniques whereby the services of physicians, experienced medical technicians, and automated analyzers are used to determine the physiology of the human body.

## National League for Nursing Surveys Education Financing

A national study on the costs of nursing education and students' sources for financing preparation for RN careers is being conducted by the National League for Nursing under a grant of $60,917 from the Division of Nursing, USPHS.

The primary purpose is to collect information as an aid in formulating federal policies on financial assistance for nursing students.

Questionnaires have been sent to more than 15,000 students in 134 nursing programs, selected at random, constituting approximately 15% of the national nursing school student body.

The results, when published, will be of value to counselors, student candidates and their parents, educators, and health career program leaders.

## Physicians' Assistants Certification Program

A new national project leading to the certification of physicians' assistants is being undertaken by the American Medical Association and the National Board of Medical Examiners.

The objective of the project is to determine the best way of developing nationally validated certifying examinations that will ensure the orderly development of the concept of the assistant to the primary care physician.

A physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.

The new program reflects the action of AMA's House of Delegates last December which directed AMA's Council on Health Manpower to assume a leadership role in establishing national certification for the assistant to the primary care physician.

At its recent meeting, the AMA Board of Trustees formally approved a proposal that the Council on Health Manpower collaborate with the National Board of Medical Examiners in development of an examination for certification.

Concurrently, the National Board of Medical Examiners, at its Annual Meeting, had recognized the urgent need to develop valid and reliable certification examinations for this category of health personnel and had directed the staff to take appropriate steps to meet this need.

The joint proposal further recommends creation by the AMA of a national advisory body on certification of physicians' assistants to counsel the AMA and the National Board in general policy decisions concerning the certification program.

In addition, the National Board will appoint such committees as it deems necessary to deal with evaluation of competence and development of the certification examination. There will be interlocking membership between the AMA advisory body and the National Board committees. The National Board of Medical Examiners is undertaking to obtain the necessary financial support needed for the study and development of the new program.

The certification examination may not be available before the end of 1973.

*"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."*

*John Galsworthy*

FREDERICK J. BALSAM, MD, Editor

rehabilitation medicine

# Rehabilitation of Patients with Chronic Diseases

**DOUGLAS CARROLL, MD**
**Chief, Department of Rehabilitation Medicine**
**Baltimore City Hospitals**
**Baltimore, Md 21224**

*Information and reprint requests to Dr. Carroll.*

*"Mr. Chairman and my long-suffering, patient, inert fellow-citizens: you have heard two aspects of the tuberculosis question—first, the interesting statement with reference to the existing prevalence of the disease, from Dr. Fulton; and second, the modern means whereby the disease, in a very considerable number of cases, may be arrested. Now, what is our condition in this city, and what are we doing for the 10,000 consumptives who are living today in our midst? We are doing, Mr. Mayor and fellow-citizens, not one solitary thing that a modern civilized community should do . . . It is a story of dire desolation, want, and helplessness, and of hopeless imbecility in everything that should be in our civic relation to the care of this disease . . . .*

*"This is the whole matter in a nutshell, Mr. Mayor and fellow-citizens. Now, what are you going to do about it? Nothing. It is not the fault of the Mayor and City Council, but of the citizens, and unless you get them awake nothing can be done. If you can once get the people awake it doesn't make any difference if the Mayor and City Council are asleep. It is you, fellow-citizens, that must wake up, and if you would get awake, and remain awake a short time, I would like to tell you what to do.*

*"Mr. Mayor, you may close your ears . . . . but . . . . we want a new charter in this town. We are sick to death of Mayors, and first branches and second branches."*

> *William Osler, MD, in an impromptu speech in regard to tuberculosis in Maryland, Md State Med J 45:133, 1902.*

The situation in Maryland today in regard to the care of patients with chronic diseases is very similar to what it was in regard to care of patients with tuberculosis in 1902. The remarks of Sir William Osler in regard to tuberculosis then might just as well be said in regard to the situation with chronic diseases today. The center of power, to be sure, has shifted from the Mayor of Baltimore to the Governor of the State.

In our efforts to render conscientious medical care to patients with chronic diseases, one of the major problems arising is to answer the questions: What are the rehabilitation needs of patients with chronic diseases; if rehabilitation services are needed, how extensive should they be for patients with chronic diseases; and which patients with chronic diseases need rehabilitation services?

Over the last 15 years it has been the particular interest of this Department of Rehabilitation Medicine to attempt to answer some of these questions in regard to patients coming to a municipal hospital who have chronic diseases requiring prolonged hospitalization. The particular emphasis has been to determine how effective the rehabilitation methods used here have been in helping the patient improve his independence and reach his highest activity: physical, mental, emotional, social, and vocational.

The definition of the selection of patients, the characteristics of the sample and the methods of evaluation have been presented in my previous rehabilitation articles appearing in the *Maryland State Medical Journal* since 1968.[1-4]

Based on these methods, we have attempted to summarize our results in treating a number of the more common chronic diseases seen at the Baltimore City Hospitals in the last 15 years.

## Results

Table 1 shows the results in various diseases.

The first column, "Diagnostic Group," differentiates patients with a single disease from those with several diseases. Diagnostic Group 1 is made up of patients with no disease other than the one listed as the diagnosis. Diagnostic Group 2 means that the person has, in addition to the underlying disease, a second disease which is asymptomatic but has been discovered through history, physical examination, or laboratory study. Examples of these associated diseases of Diagnostic Group 2 are hypertension or early asymptomatic diabetes not needing treatment.

Diagnostic Group 3 includes patients who have associated diseases or injuries which do cause symptoms and therefore make impossible any evaluation of the effect of treatment on the primary disease. In patients with hemiplegia, hypertension was frequent (Diagnostic Group 2), but the added asymptomatic disease did not seem to influence the final result. In some diseases we have listed merely the number of patients in Group 3.

Column 3 shows the ages of patients in various disease categories. Patients with complete quadriplegia were younger than those with partial quadriplegia, a result of the difference in etiology of the two conditions. Trauma in young people is a frequent cause of a complete quadriplegia. In the partial quadriplegia, the age tended to be older since many of these patients had cervical spondylosis, causing spinal cord problems with relatively minor trauma.

Table I: Results of Physical Rehabilitation in selected diseases at Baltimore City Hospitals between 1955 and 1970.

| | 1 | 2 | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | | | | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Age | | MSCL | | Initial ADL | | Treatment Period (months) | | Sex | | Duration of Illness | | Results of Treatment | | | | | | No. of Treatments | |
| Diagnosis | Diagnostic Group | No. Cases | Mean | S.D. | Mean | S.D. | Mean | S.D. | Mean | S.D. | M | F | Mean | S.D. | 1 | $1_a$ | $1_b$ | $1_c$ | U | D | Mean | S.D. |
| 1. Rheumatoid Arthritis | 1 | 64 | 53 | 13 | 38 | 8 | 66 | 30 | 10 | 18 | 24 | 40 | | | 19 | 8 | 6 | 5 | 42 | 3 | | |
| 2. Parkinson's Disease | 1 | 28 | 67 | 13 | 26 | 13 | 29 | 29 | 11 | 24 | 17 | 11 | | | 1 | 0 | 0 | 1 | 16 | 2 | | |
| 3. Disseminated Sclerosis | 1 | 47 | 43 | 13 | 32 | 13 | 35 | 28 | 15 | 25 | 18 | 29 | | | 10 | 2 | 0 | 8 | 30 | 4 | | |
| 4. Quadriplegia Partial | 1 | 16 | 51 | 14 | 34 | 8 | 28 | 33 | | | 14 | 2 | 15d | 32 | 15 | 6 | 2 | 7 | 1 | 0 | 61 | 93 |
| Complete | 1 | 21 | 39 | 17 | 32 | 11 | 10 | 10 | | | 18 | 3 | 52d | 79 | 3 | 0 | 0 | 3 | 18 | 0 | 103 | 145 |
| 5. Rt. Hemiplegia | 1 | 53 | 61 | 10 | 14 | 15 | 28 | 29 | 7 | 16 | 34 | 19 | 40d | 7 | 30 | 3 | 5 | 22 | 22 | 1 | 34 | 83 |
| | 2 | 50 | 62 | 11 | 16 | 13 | 32 | 29 | 3 | 5 | 23 | 27 | 32d | 61 | 29 | 11 | 4 | 14 | 19 | 0 | 27 | 40 |
| | 3 | 100 | | | | | | | | | | | | | | | | | | | | |
| 6. Lt. Hemiplegia | 1 | 35 | 67 | 11 | 25 | 14 | 24 | 24 | 2 | 4 | 22 | 13 | 28d | 42 | 18 | 2 | 4 | 12 | 17 | 0 | 22 | 40 |
| | 2 | 33 | 65 | 12 | 28 | 16 | 33 | 25 | 2 | 4 | 18 | 15 | 39d | 67 | 14 | 2 | 5 | 7 | 18 | 1 | 18 | 22 |
| | 3 | 69 | | | | | | | | | | | | | | | | | | | | |
| 7. Subarachnoid Hemmorrhage | 1 | 28 | 47 | 14 | 11 | 14 | 14 | 20 | 6 | 12 | 4 | 24 | 11w | 11 | 14 | 5 | 5 | 4 | 4 | 0 | 42 | 77 |
| 8. Subdural Hematoma | 1 | 15 | 43 | 15 | 16 | 8 | 41 | 35 | 1 | 2 | 13 | 2 | 6w | 4 | 11 | 6 | 2 | 3 | 4 | 0 | 16 | 20 |
| 9. Trauma to Cerebrovascular System | 1 | 37 | 31 | 16 | 11 | 15 | 27 | 32 | 2 | 3 | 30 | 7 | 8w | 8 | 26 | 13 | 9 | 4 | 11 | 0 | 34 | 44 |
| 10. Acute Generalized Anoxia | 1 | 14 | 47 | 15 | 8 | 13 | 9 | 23 | 8 | 17 | 11 | 3 | 6w | 3 | 5 | 0 | 0 | 5 | 9 | 0 | 23 | 45 |

d = day w = weeks

Column 4 shows the Mental Status Check List Score (MSCL) in various diseases. We used this method on all hospitalized patients above the age of 16 referred to the Department of Rehabilitation Medicine between 1960 and 1970.

The Mental Status Check List (MSCL) is used to estimate orientation. To score maximally (50 points), the patients must have intact hearing, sight, speech, and be able to write. Physical disabilities, therefore, might prevent a maximal score. The test, in addition to testing orientation, includes successive subtractions. General information is tested in one section, abstraction ability, and identification of objects in other sections. A wide variety of mental functions are tested.

The great advantage of this test is that it has been standardized and can be given to the great majority of patients referred to a Department of Rehabilitation Medicine.

An attempt was made to establish the MSCL score on a "normal" hospital population. Patients with leg fractures and with no obvious organic neurological disease were selected as a potentially "normal" hospital population.

Patients who had incomplete or missing MSCL scores were eliminated. In addition, patients who had suffered a concussion of the brain at the time of their fracture; patients who had injured their writing hand so that they could not write; patients who were identified as chronic alcoholics; patients with cirrhosis of the liver, epilepsy, mental deficiency, cerebral vascular accidents; the blind; the deaf; and those who had been comatose or who had language difficulties were also eliminated. Thirty-four patients with leg fractures were eliminated because of other diagnoses.

Some 242 patients had no obvious associated disease; 73% had MSCL scores between 40 and 50; and 20% had scores between 30 and 39. The interpretation of proverbs was the task most frequently missed.

The second most difficult question was the identification of the Vice President of the United States. There did not seem to be any significant difference in the questions missed by different age groups. We were unable to identify social, educational, and intellectual factors contributing to the low MSCL scores in the 27% of the patients who scored less than 40. We would set the "normal" MSCL score at 40 or above for "normal" hospital population.

There is a remarkable difference between this value in right hemiplegia and left hemiplegia. There is a section in the MSCL which identifies patients with aphasia: The test also requires the patient to write his name and a test phrase. Consequently, patients with right hemiplegia (of whom most are right-handed) did poorly on the MSCL score.

The ADL scores in Column 5 reveal severe impairment, particularly in patients with Parkinson's disease, disseminated sclerosis, and rheumatoid arthritis. Many of these patients had been ill for decades and came to the Baltimore City Hospitals when the family could no longer care for them at home.

Column 6 shows that treatment varied between a mean of 15 months for disseminated sclerosis to one month for subdural hematoma. The duration of treatment was a result of hospital and financial policies as well as of need. That is, most patients with disseminated sclerosis had been transferred into the hospital for permanent care, and treatment was kept up for long periods of time. The hemiplegias, on the other hand, were admitted acutely into the Acute Hospital and were discharged after intensive rehabilitation, either to their homes or to a nursing home. Patients with acute generalized anoxia were people who had undergone cardiac or respiratory arrest and had been resuscitated by various methods. They are a residue of a larger group of people, some of whom recovered rapidly with minimal brain damage. Those represented under "acute generalized anoxia" are the ones who suffered severe brain damage and could not be discharged.

In Column 7 it is of interest that more men than women seem to have suffered acute generalized anoxia from cardiac or respiratory arrest, possibly a result of the higher incidence of ASHD among men.

The duration of illness prior to being seen in the Department of Rehabilitation Medicine (Column 8) is largely a result of referral of patients from other hospitals to the Baltimore City Hospitals. Thus, certain diseases are picked up late, after all other resources had been exhausted and permanent hospitalization seemed to be the only solution.

Column 9, summarizing results of treatment, is divided into six sub-columns. In Subcolumn 1 are listed the patients who improved significantly in ADL score. There are three possible degrees of improvement, 1a, 1b, and 1c.

1a were those who improved sufficiently in ADL score to reach 100; 1b were those who improved sufficiently to reach an ADL score of 90

to 99; 1c were those who improved in ADL score but had a final score of less than 90. Column U were those patients who had no significant change in ADL score and the final Column D were those who deteriorated in ADL score under treatment.

The final column (10) shows the number of treatments given to patients with various diagnoses. A conspicuous finding here is that quadriplegic patients received the largest number of individual treatments with the smallest return of function.

It will be noted that the Standard Deviations (SD) particularly in Columns 6, 8, and 10 sometimes exceed the Mean. This information is included to demonstrate statistically that the majority of patients had relatively short periods of treatment (Column 6), relatively short duration of illness (Column 8), and relatively few treatments (Column 10). These patients had relatively acute onsets with short hospitalization and follow-up period. The high Standard Deviations are caused by the few patients who had very long duration of illness and many treatments over a long period of time.

Table 2 shows the overall results of physical rehabilitation, summarized from Table 1. Averaging all the diagnostic groups, 45% of the patients improved under treatment.

Certain groups did extremely well: patients with partial quadriplegia, subdural hematoma, and cerebrovascular trauma. Those with Parkinson's disease, complete quadriplegia, disseminated sclerosis, left hemiplegia, and acute generalized anoxia did poorly.

**Table 2: Summary of overall results of physical rehabilitation in certain chronic diseases**

| | % Improved |
|---|---|
| Rheumatoid Arthritis | 30 |
| Parkinson's Disease | 4 |
| Disseminated Sclerosis | 21 |
| Quadriplegia | |
| Partial | 92 |
| Complete | 14 |
| Rt. Hemiplegia | |
| Diagnostic Group 1 | 49 |
| Diagnostic Group 2 | 47 |
| Lt. Hemiplegia | |
| Diagnostic Group 1 | 27 |
| Diagnostic Group 2 | 22 |
| Subarachnoid Hemorrhage | 50 |
| Subdural Hematoma | 73 |
| Trauma to Cerebrovascular System | 70 |
| Acute Generalized Anoxia | 36 |

## Discussion

The overall conclusion of this study is that physical rehabilitation in this unpromising group of patients has been of major therapeutic value.

The problems of selection of patients and of methodology have been exhaustively discussed in previous Rehabilitation Notes. There is no control group to demonstrate what would have happened if no rehabilitation had been available. Nevertheless, we believe that this study has accomplished what it set out to do: to evaluate the impact of a Department of Rehabilitation Medicine in the treatment of chronic impairments and to identify successes and failures.

One result of this study is that our efforts at rehabilitation have to be particularly directed toward the groups that did poorly. Many of these patients had been previously hospitalized and rehabilitated and came to the Baltimore City Hospitals as a final resort. It is possible that little more can be done for the patients once they have reached the final stages of disability. If this is true, it may be possible to give more comprehensive treatment and support earlier in their impairment, concentrating on secondary prevention with planning for future disability.

Rehabilitation of patients with chronic impairments is a major problem in Maryland. Over the past 20 years there has been increasing interest and effort in advancing the interests of patients with chronic diseases. It is tragic that these efforts are foundering on insufficient funding. The chronically ill are still a forgotten minority. For children and potentially employable patients, the facilities are good; for the poor, elderly, chronically ill patients, facilitites are inadequate. The situation is in many ways similar to the situation with tuberculosis which Osler described in 1902.

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**HAZARDOUS TO YOUR HEALTH, by Marvin H Edwards, Arlington House, New Rochelle, NY, 1972.**

This book is a reverse of the usual books about medicine, for it takes on the proponents of a nationalized system of medical care and points out the deficiencies in their thinking and proposals.

The general thesis of this publication is that the free enterprise system of medical service is the most economical. While it has some shortcomings, they are not of sufficient merit to warrant a complete upheaval of the present medical system to provide a common denominator of health service.

We are sure that many people would argue with the points made in this book. However, many of them make good sense. All physicians should read this if for nothing else than to educate themselves into the various niceties of congressional proposals presently before Congress.

**PRACTICE OF SURGERY, CURRENT REVIEW, by Walter F Ballinger, MD; and Theodore Drapanas, MD; The CV Mosby Co, St. Louis, 1972.**

The authors act as editors of the monthly journal *Surgery* and this book is a result of their observations in this capacity. Recognizing the need for a brief, well-organized series of reviews, each by an expert in his field, the authors did something about it.

The topics contained in this book have been culled from a large variety of subjects which, in their opinion, are of current interest and represent areas in which recent important advances have been made. The authors hope that a vehicle has been provided wherein the reader can pick the brains of an authority in the field without spending countless hours in the library culling information from a myriad of sources.

**CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT, by C Henry Kempe, MD; Henry K Silver, MD; and Donough O'Brien, MD; Lange Medical Publications, Los Altos, Calif, 1972.**

This second edition of this publication, in soft cover, focuses on the principles of essential diagnosis and treatment and on important up-to-date references. New to the book is a chapter on Ambulatory Pediatrics, a chapter on Teeth, and extensive revisions based on suggestions from readers of the first edition. It is important for any pediatrician to own this book if he wishes to ensure that his knowledge is current and up to date in this field.

**SYNPOSIS OF PATHOLOGY, by W A D Anderson, MD; and Thomas M. Scotti, MD; The CV Mosby Co, St. Louis, 1972.**

The rapid advances in basic and clinical medical knowledge have necessitated the publication of this eighth edition. A thorough revision of most parts of the book has taken place, while retaining the basic plan and structure of the text. To the individual who needs basic knowledge of disease processes, such as medical students, residents and clinicians and others in the medical and paramedical field, this book will provide it.

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# THREE DELIVERIES THAT CHANGED THE HISTORY OF THE WORLD

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*This paper, the Hundley Memorial Lecture in Gynecology, was delivered at the 174th Annual Med-Chi Meeting in Baltimore, May 4, 1972. Information and reprint requests to Dr. Hellman.*

Disregard for history and disdain for its relevance are symptomatic of the malaise of today's youth culture and of the society which nurtured it.[1] It is difficult to believe that this disregard for the significance of the past will endure for long. Man may not have profited greatly from the lessons of history but he has always been fascinated by its inexorable march and its effect on his status.

There have been instances we will never forget where history seemed to have stood at the crossroads. The testing in the small room underneath the football stadium at the University of Chicago, the Battle of Midway, and the tragedy at Dallas are but a few examples. Each of our lives has been unalterably changed by these events. Most crucial historical crises are related to war or violence. Less noticed events, however, may have had an equal impact on the course of our lives.

Today I have chosen to discuss obstetrical practices surrounding three births which I believe changed the history of the western world. In one, the infant survived; in another, he was stillborn; and in the third, he suffered a birth injury. In each instance had obstetric practice differed, or had modern obstetrics been available, each of us would have lead different lives.

## Jane Seymour

In the first instance, the patient is a white primigravida about 30 years of age. Although she used no contraceptives and she and her husband were sexually active, she did not become pregnant until six and a half months after her marriage. Her husband had been married twice before and from each of his previous marriages a daughter had been born. Having had no sons, the outcome of the present pregnancy was doubly important to him.

The patient's last menstrual period occurred in January and her prenatal course was uneventful, although she worried constantly about death. According to the custom which prevailed, she remained in her room without exercise or fresh air for a month before her expected date of confinement. Her diet may well have been deficient. Certainly she had no supplemental iron or vitamins.

Labor began spontaneously about 5:00 PM on October the 10th. The patient was examined by her physician, Dr. Owen, a few hours later and found to have a rather small infant presenting by the vertex with the head not engaged. The membranes had ruptured. The cervix was thick, only a fingertip dilated, and the head was three fingers above the spines.

The pains were never good or well coordinated. After about 24 hours of labor the cervix was only five to six centimeters dilated with the head just below the spines and the uterine contractions weak and ineffective. The scant amniotic fluid was meconium stained.

Sometime during the next few hours, Dr. Owen and his consultants went to inform the father of the state of affairs. Had the year been 1972 and the father an ordinary person, the problem could have been solved by the earlier use of oxytocin or, even at this late hour, by cesarean section. The year was not 1972 but 1537 and the father was no ordinary mortal but Henry VIII, King of England. The patient was Jane Seymour, his third queen (Fig 1). Henry had looked forward for many years to the birth of a healthy male legitimate heir to the Tudor line.

What took place in the consultation between Henry and Dr. Owen is of course unknown. There is some evidence, however, to support the rumor that when the King was told that a craniotomy or cesarean section would be necessary to terminate the protracted labor, he directed the doctors to "Save the life of the child, for another wife can easily be found."

On Oct 12, 1537, about midnight, a puny living male infant was delivered; whether by cesarean section or vaginally will never be known for certain (Fig 2). Neither Jane's letter to the Privy



Fig 1: Jane Seymour (1536). From the painting by Holbein in the Belvedere Gallery, Vienna.



Fig 2: Prince Edward (about 1540). From the painting by Holbein in the Royal Picture Gallery at Hanover.

Council, signed two days later, nor the doctor's certificate mentions an operation. Jane, although obviously ill, was carried on a stretcher to attend the Prince's baptism on October the 16th.

On the day of her death, the doctors reported to the Privy Council as follows:

"These shall be to advise your Lordships of the Queen's estate. Yesterday afternoon she had a natural lax by reason whereof she began to lighten and (as it appeared) to amend, and so continued till towards night. All this night she hath been very sick and doth appare than amend. Her confessor hath been with Her Grace this morning, and hath done what to his office appertaineth and even now is preparing to Her Grace the Sacrament of unction. At Hampton Court this Wednesday morning at eight a clock."

Your Lordships at Commandment.
Thomas Cutland.
Robert Karhold.
Edward Bayntam.
John Chambers, Priest.
William Butts.
George Owen.

Clippindale[2] believes that "natural lax" refers to a peritoneal effusion although, more accurately, it should indicate diarrhea. Death occurred on Oct 24, 1537, probably caused by peritonitis. The evidence against the supposition that Edward was delivered by cesarean section is twofold: 1) there is no official mention of an operation and 2) the Queen lived for 12 days after delivery. In those days when the uterine incision was not sutured, death almost inevitably occurred quickly from postpartum hemorrhage or from discharge of infected uterine content into the peritoneum.

It may be rash to assume that delivery was by cesarean section. It seems equally rash to take the opposite viewpoint. Rumors concerning people in high stations often have some basis in fact. The following ballads written at the time of Jane's death indicate the strongly held belief that her delivery was by cesarean section.

1. When as King Henry ruled this land,
He had a Queen, I understand,
Lord Seymour's daughter, fair and bright;
Yet death, by his remorseless power,
Did blast the bloom of this fair flower.
O mourn, mourn, mourn, fair ladies,
Your Queen, the flower of England's dead.

The Queen is travail pained sore,
Full thirty woeful hours and more,
And no ways could relieved be,
As all her ladies wished to see
Wherefore the King made greater moan
Than every yet his Grace had done.

Then being something eased in mind,
His eyes a troubled sleep did find,
When dreaming he had lost a rose,
But which he could not well suppose
A ship he had a "Rose" by name,

Oh, no, it was his Royal Jane
Being thus perplexed with grief and care
A lady to him did repair,
And said, "O King, show in thy will
The Queen's sweet life to save or spill."
"Then as she cannot saved be,
Oh save the flower though not the tree."
O mourn, mourn, mourn, fair ladies,
Your flower, the Queen of England's dead.

2. Oh women, oh women,
If women ye be,
You'll send for King Henry
To come and see me.

Oh, King Henry, King Henry,
If King Henry ye be,
You'll send for the doctor
To come and see me,

Oh Doctor, oh Doctor,
If Doctor ye be,
You'll open my right side
And save my baby.

They churched her, they churched her,
They dug her her grave,
They buried her body,
And christened her babe.

3. The surgeon was sent for, he came with all speed,
In a gown of black velvet from heel to the head;
He gave her rich caudle, but the death sleep slept she,
Then her right side he opened and the babe was set free.

The babe it was christened and put out and nursed,
While the Royal Queen Jane lay cold in the dust.

4. Queen Jeanie, Queen Jeanie, travelled six weeks and more
Till women and midwives had quite given her o'er.
"O, if ye were women as women should be,
Ye would send for a doctor, a doctor to me."

The doctor was called for and set by her bedside,
"What ails thee, my ladie, thine eyes seem so red?"
"O doctor, O doctor, will ye do this for me,
To rip up my two sides and save my babie?"

But with sighing and sobbing she's fallen in a swoon,
Her side it was ripped up and her babie was found.
At this bonnie babe's christening there was mickle joy and mirth,
But bonnie Queen Jeanie lies cold in the earth.

N.B.—It will be noticed that in all these rhymes the Queen showed a strong desire to save her child's life.*

** It need scarcely be said that Hampton Court Palace is haunted by the ghost of Queen Jane. On each anniversary of the Queen's death, at midnight, the apparition, in orthodox style, clad in a shroud, and holding a taper, passes along a corridor and enters the room in which the confinement took place.*

While some doubt exists about the validity of the reported deliveries of living children by cesarean section in ancient times, there can be no doubt that the operation was well known in antiquity. It is almost certain that cesarean section was successfully performed on living women by the later half of the 16th Century. Authoritative statements by dependable obstetricians about the early use of the operation did not appear in the literature until the mid-17th Century, as for instance in the classic work of the great French obstetrician, Francois Mauriceau, first published in 1668.[3] In writing on the subject, Mauriceau mentions that Jane Seymour was delivered by cesarean section.

Although most deaths from early cesarean section occurred from hemorrhage or shock soon after the operation, a few patients could have lived as long as 12 days, and later death could reasonably be attributed to peritoneal infection. At the time of Jane Seymour's delivery, Hampton was isolated from the world by order of King Henry because plague was raging in London. The operation could have been performed with little public record or knowledge. Henry had the will and the ruthlessness to order the procedure that virtually condemned his Queen to death. His desire for a male heir is well documented and the execution of the preceding Queen, Anne Boleyn, and her five compatriots was a far more ruthless act than the salvaging of his heir.

Henry was shrewd enough to realize the impact of his deed on public opinion. Historical accounts of the period leave no doubt that he had the power to silence speculation among the populace and certainly among his immediate household.

Only one other piece of confirmatory evidence remains. George Owen received an annuity and numerous lands from Henry. He was made executor of Henry's will and left 100 pounds.[4]

The survival of Henry's son and his subsequent reign of six years as Edward VI gave time for the establishment of Protestantism in England. Henry's eldest child, Mary, a Catholic, who assumed the throne on young Edward's death, ruled for too short a period to reverse this religious trend. Whether delivered naturally or by cesarean section, Edward's reign confirmed England as a Protestant nation and laid the religious foundation for the Elizabethan Age.[5]

## Princess Charlotte

The death of Princess Charlotte of Wales after she had given birth to a stillborn son on Nov 6, 1817 was as newsworthy in England as was the assassination of President Kennedy in the United

States. That nation also suffered prolonged and inordinate grief. Women who were beginning to think of childbirth as reasonably safe became fearful of its consequences. Lord Byron, reflecting public concern, inserted six verses in his nearly completed Fourth Canto of Childe Harold. These verses contain a twofold theme: 1) the peoples love for the young attractive and vivacious Princess, and 2) the despair of the nation over the destroyed succession.[6]

". . . in the dust
The Fair-haired daughter of the Isles is laid,
The love of millions. how we did entrust,
Futurity to her . . ."

The unique public emotion on the death of the Princess can be explained not only by her youth (she was 21), and her physical freshness and attractiveness in an age when royalty had few attractive qualities, but also because she represented the slender thread of royal succession.

Although Charlotte's grandfather, George III, had seven sons and five daughters, she was the only legitimate grandchild. Her father, the Regent and later George IV, was 55 at the time of her death and in dissipated poor health. Twenty-odd years earlier, he had agreed to an arranged royal marriage with an obscure German Princess with whom he is said to have cohabitted but once and whom he refused to see after a year of marriage. Charlotte was their daughter. The royal uncles and aunts were either unmarried, too old, sterile, or their offspring removed from succession by the Marriage Act.

Until the recently disclosed Croft papers by Sir Eardley Holland[7] from whose scholarly account of the tragedy this section of the paper is largely drawn, the public was given few facts in the case. There were some bulletins about the pregnancy and the onset of labor was announced in the newspaper. From that time until the news of Charlotte's death, however, there was no information to the public. Afterward there were a few rumors, a few letters, and a great deal of speculation, including distorted truths about the cause of death.

Four doctors were involved in this case: Sir Richard Croft, the obstetrician; Dr. John Sims, the consultant; Dr. Mathew Baillie, the Royal Physician; and Sir Everard Home, Sargeant Surgeon to the King, who performed the autopsy and acted as mortician. Three of these doctors were a close family group. Croft and Baillie had married twin daughters of the world-famous obstetrician, Thomas Denman. Home was the brother-in-law of William and John Hunter, famed English physicians, and Baillie was their nephew. As Holland states,[7] Sims, the consultant, was the mystery man. He had achieved fame as a botanist; but, as a physician and certainly as an obstetrician, he seems to have had few qualifications. It is unclear why he was chosen to help Croft with the impending important event when such renowned obstetricians as Merriman and Ramsbotham were active in London, but the choice of Sims was typical of the capricious selection of medical care for figures of public importance.

Sir Richard Croft looked good on paper. He was trained by Denman and inherited his practice. He had previously attended royalty. Despite his training and experience he was a diffident, sensitive man who lacked the self-confidence to follow a dynamic course of action that could be at variance with the authoritative concepts; just the prototype of an obstetrician who courts tragedy from inert labor. He faced this complication in its most serious form in those November days of 1817.



Fig 3: Princess Charlotte of Wales — died Nov 6, 1817.

The patient, Princess Charlotte (Fig 3), was a white, 21-year-old primigravida with a normal pelvis whose expected date of confinement was about October the 21st. Her prenatal course was

normal, although she was bled on at least three occasions. Labor began spontaneously with rupture of the membranes three weeks after her expected date of confinement on November the 3rd at 7:00 PM. An estimated 4,000-gram fetus presented by the vertex with the head engaged. On vaginal examination, the head was in the anterior position at the spines; the cervix was one centimeter dilated; pains were weak and eight to ten minutes apart.

After 16 hours of labor the cervix was only three to four centimeters dilated with the head still at the spines and the contractions irregular but extremely painful.

Dr. Croft, a little worried, wrote a note summoning his consultant, but he did not send it, probably because labor improved somewhat.

At the end of 26 hours the cervix was nearly fully dilated and the head low. The patient was not unduly fatigued, but the pains were poor and Dr. Sims, the consultant, was summoned. Dr. Croft was unwilling to use forceps without the approval of his consultant.

Dr. Sims arrived after the second stage had lasted five hours. He refused to see or examine the patient, but remained in the next room available in case an instrumental delivery became advisable.

After 15 hours of second stage the amniotic fluid became meconium stained. After 50 hours of labor, in 24 hours of second stage, with the head having been on the perineum for five or six hours, the patient was delivered spontaneously of a nine-pound stillborn male infant. In spite of the fact that the infant appeared to have been dead for several hours, vigorous attempts were made to resuscitate him.

After 20 minutes of third stage, during which time the placenta separated only partially, the patient began to bleed. Before much blood could be lost, Dr. Croft, with Dr. Sims' consent, proceeded to remove the placenta manually. He had some difficulty because the separated portion was entrapped in a firm contraction ring. Nevertheless, he was able to dilate the ring and peel off the upper two thirds of placenta and bring it down into the vagina where he left it. Sometime later, because of the patient's complaints, he removed the placenta from the vagina. It was followed by a gush of blood, but he was not alarmed about the blood and the patient felt well. Her uterus was firm and pulse not above 100.

Three hours after delivery the patient became restless and agitated. She was given some laudanum. An hour later she complained of great uneasiness in her chest and difficulty in breathing. Her pulse was feeble and irregular. She was given cordials, nourishment, antispasmodics, and opiates. She died seven hours after delivery.

At autopsy the uterus was found to contain about 500 ml of blood retained behind the still evident contraction ring. The fundus extended to umbilicus.

From a modern obstetrical view, the mistakes in the conduct of Charlotte's labor are so obvious that they could be delineated by a third-year medical student. Although Dr. Croft may have been timid and unimaginative, by the rules and principles of contemporary practice he was not wrong. After Smellie retired from practice in 1760 the forceps became much abused. William Hunter, Denman, and Osborn (who followed Smellie) overreacted to the new radicalism and introduced a retrogressive conservatism into obstetric practice whose ill effects were to persist until recent times.

This retrograde phase in the evolution of obstetrics was discussed at three meetings of the Obstetrical Society of London in 1879. In opening the discussion, Robert Barnes said:[8] "These illustrious men thought it right to exert all their authority in discouraging the use of instruments, and in indicating a blind faith in nature as the better way. So earnest was their zeal, so commanding their authority, that men were driven into the opposite extreme of supine inaction . . . Rules were laid down and widely obeyed, which too often allowed parturient women to drift into danger, injury and death."

Denman's classic text, "An Introduction to the Practice of Midwifery," first published in 1802, became an obstetrical bible.[9] Its concepts became laws so restrictive that they inhibited independent thought. Denman's law, as applied by Croft, states: "A practical rule has been found, that the head of the child shall have rested for six hours as low as the perineum before the forceps are applied although the pains should have ceased during that time." Similar restrictive rules influenced Dr. Croft's conduct of the third stage.

Sir Richard Croft shot himself three months after the delivery. He was guilty of no malpractice. A lonely man in the delivery room upon which the eyes of the world were focused, he had neither the fortitude nor the imagination to defy established tenets.

Following the death of Charlotte only the

mentally weak Duke of Brunswick, then age 13, remained in succession. The Royal Dukes abandoned their mistresses and rushed for German brides. The elderly Duke of Kent married Princess Mary Louise Victoria of Saxe-Coburg. Victoria, who at the age of 18 became Queen of England, was their child. Her reign was marked by a tremendous colonial expansion. Her conscientiousness and impeccable morals helped to restore the prestige of the Crown and established it as a symbol of public service and imperial unity. Interestingly, Victoria plays a small role in the next case which concerns her daughter. Had it not been for the hesitant obstetric practice of poor Sir Richard Croft, Victoria would never have existed.



Fig 4: One of Dernier's portraits of Kaiser Wilhelm II.

## Kaiser Wilhelm II

The grandson of Queen Victoria, later Kaiser Wilhelm II of Germany (Fig 4), sustained an injury to the left brachial plexus during his birth on Jan 27, 1859. The resultant withering of his arm was for many years the subject of speculation and gossip. Some of the rumors were undoubtedly initiated by the royal midwife who was offended when her role was taken over by male obstetricians. Others stems from efforts to attribute the Kaiser's impulsive behavior (his love of the military and his belief in the divine right of Kings) to a physical deformity. There can be little doubt that Prussian militarism looked with disdain on any physical weakness. The Kaiser was sensitive about his deformity and overreacted to it. The psychological impact of this birth injury, occurring in a ruler of a nation convinced that it had been deprived of its share of the world's goods by the major powers, and in a nation already committed to military might, could have provided an impetus to the first World War.

The true story of the birth of Wilhelm II has received scant attention in light of its historic importance. The following documents from Dr. Eduard Martin. the obstetrician, and his son, Dr. A. Martin, were made available to us from the Archives of the Prussian Royal House and have been translated into English by Dr. Ralph M. Wynn.

HM T St No. 1494/31
Berlin -Schöneberg, . . . Dec. 1928
Freiherr von Stein-Str.2.

Your Majesty, May I be permitted to submit the following:

My father, Privy Medical Counsellor Prof. Dr. Eduard Martin, from 1858 to 1875 Specialist in Obstetrics at the University of Berlin, was honored to be permitted to assist your Majesty's mother at your Majesty's birth. There are all kinds of rumors going around in the press and literature about this action of my father, reproaching him in a most offending manner. All these rumors, irresponsibly exploited and expanded by authors without any authentic basis, are only too likely to slander my father's memory.

I have until now remained silent to all criticisms in the belief that these untrue and disparaging reports would cease by themselves. I was, furthermore, also reluctant to publish my father's report, which he wrote on the basis of his diary 12 days after your Majesty's birth. In view, however, of the attacks upon by father, which keep reappearing in the literature concerned with your Majesty, I feel the cogent obligation to counter the malevolent and totally unjustified abuses against my father with the publication of the authentic material.

At stake is the honor of a scholar of high repute, a highly esteemed representative of the University of Berlin in the worldwide circles of those who were entrusted to his care.

Before publishing the herewith attached material I ask your Majesty for a gracious communication indicating whether your Majesty has any objections.

As your Majesty will see from my report, it limits itself entirely to the essential facts. I have consistently avoided any polemics. Knowing that my father throughout his career as an obstetrician enjoyed high and frequently shown appreciation in your Majesty's family, I do not believe that I am making an inappropriate request in asking for your Majesty's consent to the publication of the herewith attached statements in order to safeguard my father's memory against further unqualified insults.

Your Majesty's
most humble,
/S/ A. Martin

There is no record that this request was granted and it is assumed that the following material was never published.

Report of Dr. Eduard Martin on the Delivery of the Empress February 9, 1859 and Supplementary Report of Professor A. Martin of April 28, 1931.

REPORT

on the Delivery of Her Royal Highness the Princess Friedrich Wilhelm, Princess Royal of Great Britain.

The undersigned was summoned to the Palace at ten o'clock, after labor had started in the early hours of January 27 and the membranes had ruptured allegedly between 5 and 6 in the morning. At 10:30 A.M. I found the cervical os dilated to about 1½ inches in diameter but tight, and the right buttock of the fetus in it, the anus to the left and backward. The labor, though very painful, was not very effective; the pulse rate between contractions was 8 to 9 in 5 seconds and it increased to 12 to 13 during contractions, indicating spastic, dysfunctional labor. The illustrious parturient was therefore given one grain of ipecacuanha at about 11 o'clock, which caused her to vomit once. Labor appeared to have improved but was still very painful. I therefore recommended moderate inhalation of chloroform, which soon alleviated the great agitation of the Princess. Her Royal Highness complained of unusually violent pains, however, whenever the moderate anesthesia subsided, asking most touchingly for sympathy and apologizing for her loud complaints. Around 1 o'clock P.M. the dilatation of the cervical os increased, and the protruding buttocks descended in appropriate lateral position in the pelvic passages. As the buttocks finally appeared between the labia, at about 2 o'clock, while contractions though frequent did not seem sufficiently forceful and sustained, there was reason to suspect inadequate uterine activity during the expulsion of the child as well as faulty contraction afterwards. I therefore recommended administering secale cornutum as I had always done most successfully in similar circumstances. (Among others, even on the preceding as well as on the same day, were two primiparae in the Royal Institute of Obstetrics, one a woman of 37 and the other one of 20, whose babies similarly presented as breeches and, like their mothers, were kept in good condition by means of the same procedure.) The secale cornutum repeated 3 times, 10 grains each time, had the desired effect that the illustrious parturient was no longer harassed so frequently by contractions, which, on the other hand, increased in strength and expulsive efficiency.

Thus, the buttocks emerged from the vulva at 2:45 P.M. with the prince's legs folded upwards on his abdomen and chest. When, at this point, I felt the pulse in the umbilical cord weaken, slow down, and even become intermittent, the manipulation that had become necessary had to be made safe. To this end, deeper chloroform anesthesia was administered and, thus, the indispensable total quiet and analgesia of the illustrious parturient was effected. I carefully raised the prince's legs, which were folded upwards, and, since his life was seriously endangered, I immediately guided his arm, which was stretched upwards and backwards alongside his head, downwards, according to the correct procedure. It involved considerable effort, as is understandable in view of the narrow genital passages, while I used the arm, according to the tested precepts of obstetric art, to turn the child's body around. Then I released the right arm, which was also stretched upwards and finally the head, turning (according to Smellie's wise rule) the face back toward the hollow of the sacrum and bringing it out carefully. As the weakening pulse in the umbilical cord had already indicated, when only the buttocks had been delivered, the prince appeared quite lifeless, but the usual means of resuscitation sufficed to initiate his breathing even before I brought him to the bath that was kept ready, and he opened his eyes.

After thorough consideration of all circumstances and use of my wide experience, I am still convinced that the prince would have lost his life had the procedure been different.

Her Royal Highness the Princess awoke after about a quarter of an hour, highly pleased with the painlessly completed, happy delivery, when she heard the prince's cries from the next room. Her gratitude for the help I had given was as pleasant as it was moving. The uterus had contracted very well and about half an hour later the placenta lay in the vagina, whence I removed it without causing the Princess any pain, while she carried on a conversation with Dr. Schönlein.

The further course of the puerperium was normal, more so than might be expected of a primipara.

Berlin, February 9, 1859 Dr. Eduard Martin

Medical Privy Counsel
Prof. Dr. Aug. Martin.
Berlin.

From January 1859 to the present time the most malevolent reproaches against my father have been leveled in the press on the basis of statements made by the midwife on duty and by ladies of the court. These statements have been repeatedly expanded by writers, biographers, and historians, without any authentic, official statements at their disposal.

The criticisms raised against Professor Martin were:

1). he had not responded immediately to the call for obstetric assistance;

2). he injured the child during birth;

3). he caused the apparently dead child to be put aside, considering its resuscitation impossible.

To 1). After repeated discussions with my father I state that he answered the call with particular promptness, since it reached him just as he was about to enter the opened door of his coach in the street in front of his apartment en route to the Charité, where he was to give a lecture.

On January 26, 1859 in the family of Prince Friedrich Wilhelm (later Emperor Friedrich III), the father, then Prince Regent, (later Emperor Wilhelm I.), insisted that, in addition to the English obstetrician whom the Queen of England had requested for the occasion and to the staff physician assigned to the Prince, the consultant of Berlin University, Professor Martin, be called in: The invitation to Prof. Martin was sent in a letter by City mail on the evening of January 26! This letter arrived at 5 Dorotheenstrasse, then the Gynecological Clinic of the University, in the morning mail on January 27. It was handed to my father, who had already entered the rooms of the Clinic at 8 o'clock for his daily rounds, along with the rest of the incoming mail, as he was about to leave, at 10 o'clock, for his lecture at the Charité. At that moment a lackey of the Crown Prince came running to ask whether the Professor wouldn't want to come?! My father immediately directed his carriage to the Palace.

To 2). The two consulting obstetricians, as mentioned above, had not the previous evening made the diagnosis

that the child was presenting by the breech. The report for the Queen of England shows that my father conducted the delivery in exemplary fashion. The delivery was complicated by a disturbance called "spastic labor" by obstetricians. With this complication, the uterus contracts, becoming as hard as wood, while pains continue. The illustrious parturient had been suffering throughout the night with great patience. The drugs administered by my father eliminated this spastic condition with appropriate speed, thus making possible a normal course of the delivery. The family physician of the Royal House, the very famous Professor Privy Counsel Schönlein of Berlin, had joined in the observation of the delivery. The report shows that, in addition to the obstetrician, the other physicians present observed the infant continuously without noticing any bodily abnormalities. Special importance must be attached to this connection to the judgment of Privy Counsellor Schönlein (at the time the most famous physician and scholar in Berlin and intimate family physician of the Royal House), who had meanwhile also come to the Palace. Schönlein congratulated my father most cordially on his artfully accomplished assistance.

When, upon the birth of the buttocks, the child's heart tones disappeared and the umbilical pulse weakened, my father expertly delivered the body, legs, arms, and head. Notwithstanding the narrowness of the pelvic passages, he fulfilled this task without injury to the soft parts or to the child, as the physicians present stated with vigorous appreciation.

To 3). The report to the Queen shows that it was my father who personally made the efforts to resuscitate the deeply comatose infant. Through continuous rubbing of the infant's body, pouring cold water over the child in the warm bath, and short, strong slaps on the buttocks, my father induced the child to breathe. Only after about half an hour of eventually successful efforts did he with his own hands place the infant into the hands of the midwife on duty. The child appeared to be quite normally developed; there was no thought of disfigurement of any part of his body, or of a bony fracture or any thing of the kind. The first cries found a lively welcome among the persons present, who were greatly relieved. All congratulated the successful obstetrician, especially the Royal grandfather, who heartily shook my father's hand and remarked: "But this is not the way to beat Prussian princes!" The physicians present, particularly Mr. Schönlein, having examined the infant, expressed their appreciation repeatedly to my father.

Only 3 to 4 days later was it noticed that the child's left arm was limp. Treatment was entrusted to appropriate specialists, not to the obstetrician.

Having no reason to assume that my father, the highest authority among his colleagues at the time, and Mr. Schönlein could have overlooked an injury to the bone or joint during inspection and palpation of the infant, I consider the developing change in the left shoulder and the left arm a result of the pressure exerted by the arms, hands, and feet, which were folded upward during birth, upon the nerve plexus of the neck, which influences motion and development of the arm (now called "Duchenne-Erb paralysis"). The premature rupture of the membranes and the long-lasting, very violent, spastic contractions of the uterus certainly played their fateful part.

The very happy mother was especially grateful to my father. The first manual work she was permitted to perform was the preparation of paper spills for my father, who was not a smoker. The parents also later remained graciously thankful to my father, who was again in contact with Their Highnesses for weeks while staying in the New Palace in Potsdam in 1860, waiting for the second delivery. Title and decoration were, of course, awarded before long.

. . . April 28, 1931 A. Martin.

Skillful as Dr. E. Martin undoubtedly was, there can be little doubt that the brachial plexus was injured during the partial breech extraction. Dr. Martin's report is not sufficiently detailed to fix the precise moment of the accident. Apparently, however, the left arm was extracted with difficulty. The fetus lay, originally, with his back to the mother's left and his left arm anterior. Inasmuch as the left arm was extracted first the injury must have occurred either when the anterior shoulder was pulled beneath the symphysis, during the extraction, or when the arm was used to turn the fetus. Dr. Martin was faced with the serious obstetrical complication of having to perform a partial breech extraction on a primigravida with a contracted pelvis. The bilateral nuchal arms compounded the difficulty; they are not uncommon in such cases. Modern obstetric practice frequently suggests that extraction of the posterior arm first is easier than the procedure performed by Dr. Martin. Certainly an episiotomy simplifies the operation. Martin, however, followed standard teachings of his time and in this respect his conduct of the labor was exemplary. The accident was more inherent in the circumstances than in the obstetrician.

I have selected three striking instances where obstetric practice has had more than a passing influence on world events. Few obstetricians are placed in positions similar to those presented to Owen, Croft, and Martin. Each birth alters history in its own way. No man is an island, no birth is without its influence on the individual and thus on many people, occasionally on history. In this respect the responsibility of the obstetrician is without parallel in medicine.

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# A FUNCTIONAL RESPIRATORY CARE SERVICE

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There is a distinction between Inhalation (Respiratory) Therapy, and the Respiratory Care Service (RCS) within which Inhalation Therapy operates. Inhalation Therapy is a well-established, physician-directed activity performed by professional technicians. A Respiratory Care Service is an autonomous medical service and a relatively new activity.

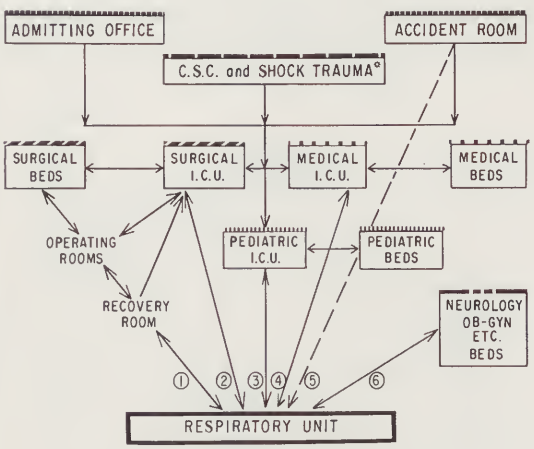
The Director of a Respiratory Care Service (or Division) should be an MD, trained and experienced in acute medicine, with a special background in pulmonary physiology and a deep clinical knowledge of respiratory problems, equipment, and patient care. A Division of Respiratory Care may be organized and administered within a Department of Anesthesia, but an internist, surgeon, etc, with a penchant for this practice of medicine may head such a unit. Anesthesiologists, who practice "coma creatoring" and "respiratory depression," intubate, oxygenate, and supply mechanical ventilators routinely, and therefore have the basic expertise necessary for this work.

The RCS is defined as a complete hospital facility organzied to deal with respiratory problems 24 hours a day.[1] The patient in respiratory failure, defined by abnormal blood gases,[2] may be referred from a surgical, medical, or other service; his need for respiratory support crosses departmental lines, and physicians on the RCS are "immediate" or "acute" consultants. For this necessary and beneficial service to be effective, inclusive support from the following becomes an integral part of a functional Respiratory Care Service:

**I. A Respiratory Intensive Care Unit**
**II. An Inhalation Therapy Service**
**III. A Chest Physiotherapy Service**
**IV. A Pulmonary—Function Laboratory including blood-gas analysis facilities**
**V. Research and In-service Education**
**VI. Outpatient and Emergency Room Service**

## I. Respiratory Intensive Care Unit

This facility provides space, staff, and equipment oriented toward intensive therapy and monitoring of a patient in respiratory failure.[3,4] It provides continuous treatment and observation of such patients, extending throughout all hospital wards and intensive care areas (Fig 1).




ADMISSION TO RESPIRATORY UNIT

°C.S.C., THE CLINICAL STUDY CENTER AND SHOCK TRAUMA ARE SPECIAL PATIENT CARE AREAS.

Fig 1: Admission To Respiratory Unit

Respiratory patients outside the Unit are seen daily from a respiratory standpoint on a consultant basis until they leave the hospital. The Unit maintains its own 4-to-8 bed patient area. Such a Unit is the heart of the Respiratory Care Service and its personnel, equipment, and patient-care technique stand as a beacon-light for excellence and the primary source of modern clinical respiratory teaching for the hospital.

**The RCS Medical Director** controls admissions, discharges, and respiratory care technique and procedures; coordinates overall patient care;

and manages budgets for the Unit, Inhalation Therapy, Chest Physiotherapy, and other involved services. Patients admitted to the Unit remain patients of the admitting doctor, but it is advisable that all physicians' orders be written by the RCS Medical Director and staff. He should have the authority to purchase small pieces of equipment as well as to make capital improvements within the purview of respiratory care. Although major policy involving patient care or departmental and staff physician relationship must be approved by the hospital medical board, the necessity for the board to appreciate some degree of independence where respiratory care is involved is paramount.

**An Assistant Medical Director**, with similar background and abilities to those of the Director, is necessary at staff level to complement the Director; one or the other is on 24-hour call. Residents from Anesthesia and all major hospital departments should rotate through the RCS (Fig 2) for from two to six months for two purposes: 1) to learn principles of proper respiratory care which they can bring back to their departments and utilize, and 2) to provide 24-hour coverage for the Unit.

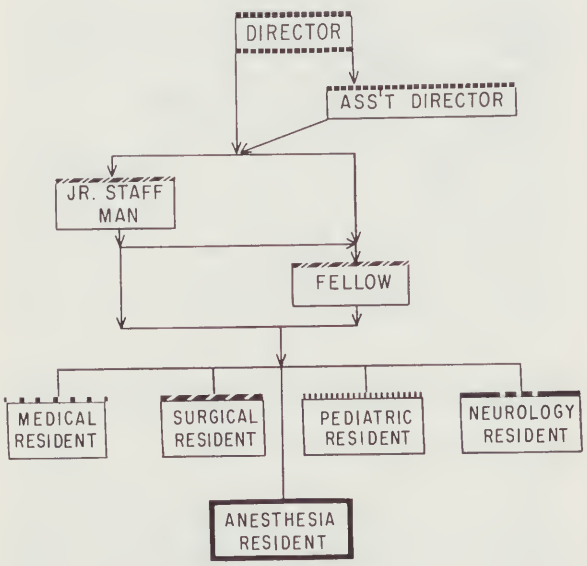



Fig 2: Rotation Of Personnel In Respiratory Unit

An MD must be on the premises of the Unit at all times. Since patients in the Unit will have many and varied diseases, the entire spectrum of specialty consultants should be available for bedside help with cooperation from the admitting physician. The Director and his Assistant should have an office near the Unit, with a neighboring conference room and library. Residents should have a sleep-in area within the Unit.

Adequate and competent nursing personnel are critical. These patients require more than monitoring; they need active therapy, including suctioning, turning, chest physiotherapy, humidification, ventilator adjustment, medications, etc. A 1/1 nurse/patient ratio is necessary, but not all need be registered nurses. The factor of 4/5 nurses per bed takes into consideration the 21-shift-week nurse/bed ratio, and sickness, holidays, and vacations (Fig 3).

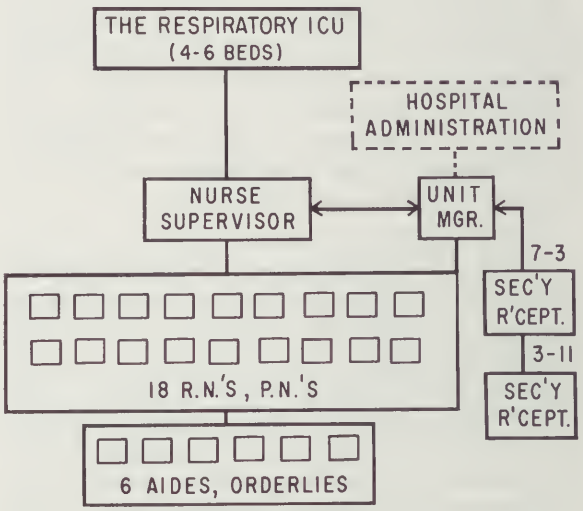



Fig 3: The Respiratory Intensive Care Unit

Functionally, these nurses must be independent, with their own nurse chairman, their own duty roster, and be free from call to duties outside their Unit. If a Unit has its nurses reduced, it now becomes a Unit with so many less beds although space for patients exists. A six-bed Unit with nurses adequate for three is a three-bed Respiratory Unit; if more than three patients are in such a Unit, it becomes an Intensive Monitoring Unit, an Intermediate Care Unit, and one with poor nursing morale.

**A Unit Manager** should work within the Unit, in cooperation with the head nurse, as an extension of the hospital administration. He orders supplies and equipment; facilities maintenance, repair and supervision of equipment; and assists the hospital Director, Medical Director, and head nurse in selection and direction of ancillary personnel, including aides and orderlies. A secretary-receptionist should function from 7:00 AM to 11:00 PM, primarily for telephone calls and visitors.

## II. Inhalation Therapy Service

This Service must offer 24-hour coverage, seven days a week[5,6] under MD supervision, usually the Medical Director of the Respiratory Care Service or his Assistant. Personnel include a chief therapist, staff therapists, and equipment technicians (Fig 4).

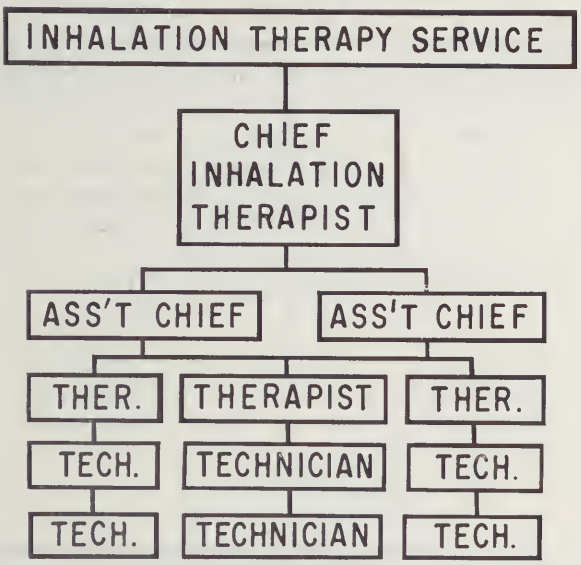



Fig 4: The Inhalation Therapy Service

The chief inhalation therapist supervises personnel and procedures, records, systems, equipment sterilization and maintenance, keeps the inventory up to date, and supervises ordering of supplies. He must understand all types of inhalation therapy equipment, create procedural manuals, and conduct teaching programs for his personnel. An adequate record system must be maintained according to state laws and medical board rules. Patient-equipment rounds are made on each shift. A radio-paging system is essential. He should have American Registry of Inhalation Therapy (ARIT) Certification.

The hospital administration must provide the necessary space and facilities for immediate and future needs. A general guideline might be 3,000 sq ft for a 500-bed general hospital.[5] The Inhalation Therapy area ideally should be close to patient care areas and should include classrooms, locker rooms, the pulmonary function laboratory, an outpatient therapy room and reception area, the chief technician's office, a large storage area, and workshop and maintenance space.

**Other inhalation therapy personnel** should be grouped according to their level of training, skill, and ability. The following classification has been suggested:[5,6]

**Group A**

These are relatively unskilled aides or attendants — descendants of the "tank jockeys" and sometime oxygen therapists of a few years back. They transport patients receiving oxygen, gas cylinders, and other special equipment; and clean, sterilize, package, and service equipment and supplies. They should not, however, come into actual close contact with patients; they do not attach ventilators to patients.

**Group B**

These therapists are more experienced and skilled either through years of practice or by attending a school of inhalation therapy. They handle patients under the direction of physicians and nurses, and have some knowledge of respiratory diseases. Group B therapists may conduct intermittent positive pressure breathing (IPPB) and aerosol treatments. As they become more knowledgeable, they may perform chest physiotherapy, postural drainage, suction endotracheal and tracheostomy tubes, and participate in cardiopulmonary resuscitation. From these therapists come many Certified Inhalation Therapy Technicians as designated by the American Association of Inhalation Therapy.

**Group C**

These are the experienced and knowledgeable therapists, Registry-eligible or already certified. They adjust ventilators, either in response to physicians' orders or independently — but always under the physician's supervision. Their knowledge of blood gases and pulmonary physiology gives them insight into patients' diseases and they often suggest and even innovate. Under supervision, they may withdraw arterial blood and operate blood gas electrodes. Such therapists may be skillful enough to intubate tracheas in emergencies. They serve as instructors for nurses, house staff, students, and Group A and B therapists.

## III. Chest Physiotherapy Service

The physiologic rationale behind chest physiotherapy includes the relaxation of musculature to avoid muscle splinting, the training of patients in the effective use of normal and accessory respiratory muscles for effective sighing and coughing, and periodic complete lung expansion.[7] The purpose of chest physiotherapy is twofold: 1) to prevent respiratory complications, and 2) to improve pulmonary function in acute or chronic pulmonary disease.

Techniques include breathing exercises, passive and active; coughing exercises; manual vibration and percussion; mechanical percussion; postural drainage; and positional techniques.

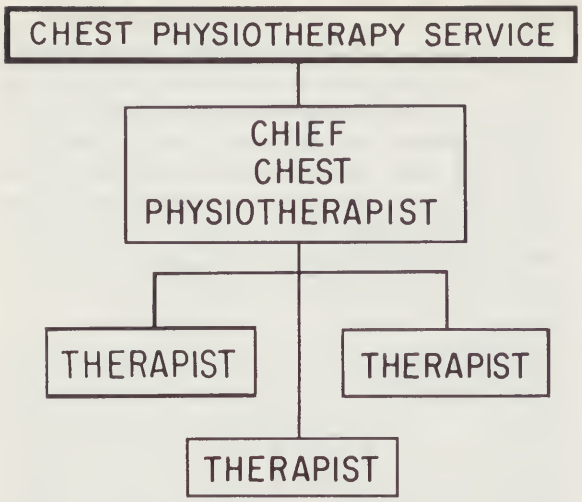



Fig 5: The Chest Physiotherapy Service

The effectiveness of chest physiotherapy in both medical and surgical patients has been demonstrated, particularly in Scandinavia and Great Britain, although it has developed slowly in the United States. This is probably attributable to improvement which is undramatic and difficult to measure.[8]

Such a service requires a director analogous to the Director of an Inhalation Therapy Service, and a number of therapists (Fig 5). An office is necessary; but, in contrast to the Inhalation Therapy Service, relatively little equipment is required. This service should integrate its activity with Inhalation Therapy; both work within both the hospital wards and the Respiratory ICU. In the future, a "chief respiratory therapist" will probably integrate chest physiotherapy and inhalation therapy activities (Fig 6).

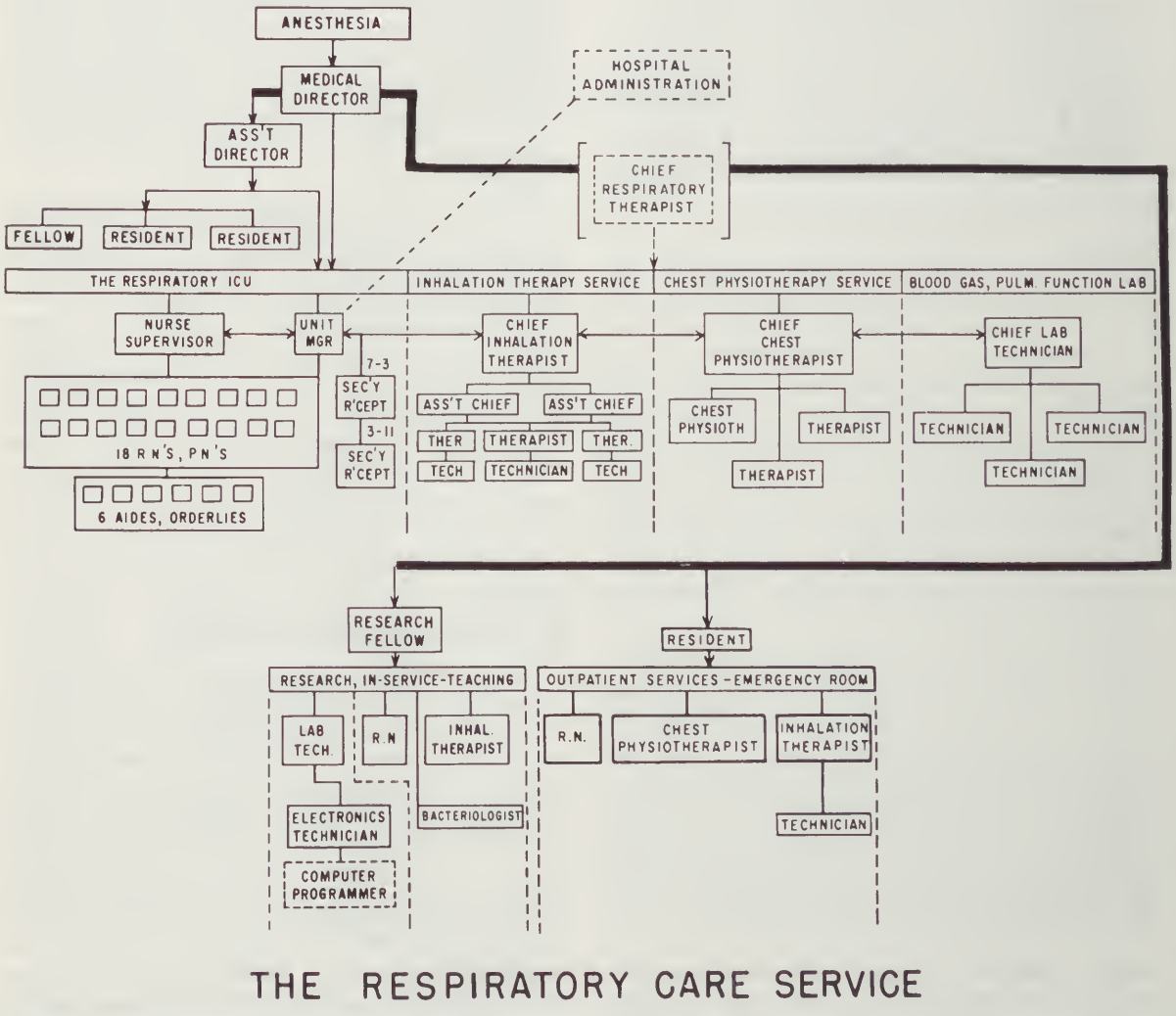



Fig 6: The Respiratory Care Service

## IV. Pulmonary Function Laboratory

A blood-gas analysis laboratory, open 24 hours a day, with a full-time chief and technicians, should be in or near the Respiratory ICU (Fig 7). The Medical Director must exercise rigid quality control of the equipment; there should be two sets of all electrodes in working conditions at all times.

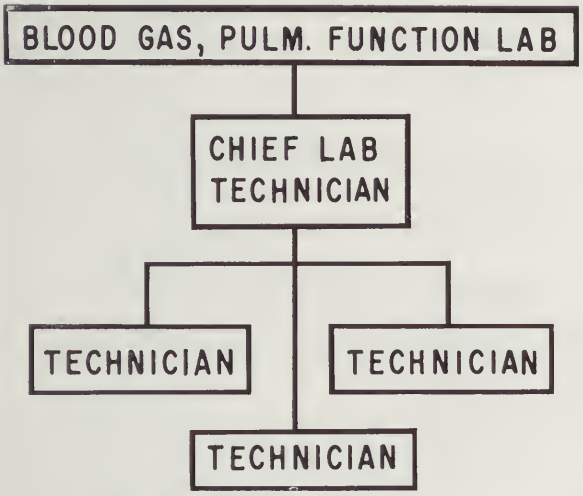



Fig 7: Blood Gas And Pulmonary Function Laboratory.

The technicians in this laboratory should be well versed in spirometry and the use of oxygen and infrared carbon dioxide analyzers allowing for accurate estimates of $V_D/V_T$ ratios and percent venous admixture. In more advanced laboratories, more complete pulmonary equipment may be available, with tests including inert gas uptake and body plethysmography.

## V. Research and In-service Education

Personnel for research and in-service education includes a nurse specialist, an inhalation therapist, and a laboratory technician working with the Medical Director, his Assistant, and a research Fellow, all involved in active clinical and laboratory research (Fig 8). This team also has the obligation to teach proper principles of respiratory care to registered and practical nurses, and physicians at all levels in all areas of the hospital, especially in the Intensive Care Units. Throughout the academic year, a schedule of lecture-demonstration programs should upgrade and maintain techniques and knowledge concerning practical subjects, such as tracheostomy care.

**An Electronics Technician** is necessary to service, repair, set up, and change the complicated instruments and apparatus within the Division, ranging from monitors, oscilloscopes, and carrier

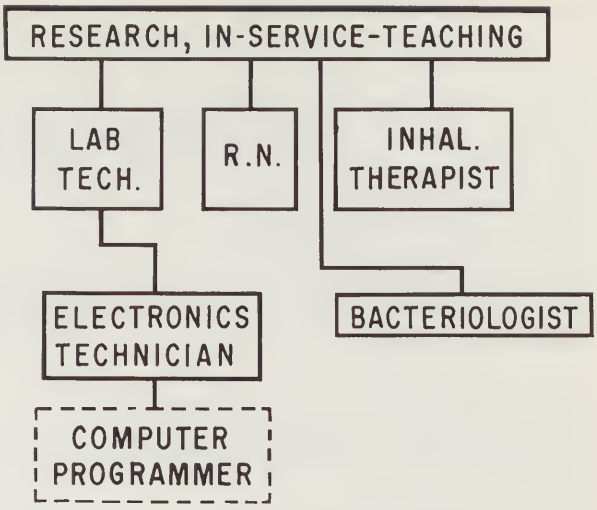



Fig 8: Research And In-service Teaching

amplifiers to telethermometers, oxygen analyzers, and transducers.

In larger hospitals, a computer programmer may develop techniques for on-line data acquisition, data processing, and simulation of those physiologic systems referrable to Respiratory Care. Programs to alarm personnel to changes in physiologic variables beyond set limits may be created. Research data stored on magnetic tape would be statistically off-line analyzed by programs written by such a systems analyst.

**A Bacteriologist,** working with the Medical Director, should create rules to prevent the spread of infection and teach these as standard operating procedure. Proper asepsis, whether through autoclave, ethylene oxide, or cold sterilization, must be taught. He is also responsible for routine culture of humidifier contents, tubing and other equipment, and for designating susceptible and sensitive areas.

## VI. Outpatient Services - Emergency Room

This Service includes physician leadership and personnel including a nurse, inhalation therapist, chest physiotherapist, and a laboratory technician. Many ambulatory patients will be seen routinely on an appointment basis, and emergency room patients in respiratory distress are also treated on an ambulatory basis. Victims of asthma, emphysema, bronchitis, etc require aerosol treatments, positive pressure breathing, chest physiotherapy, and prescription medication. Blood gases and spirometry should be available. These patients must be able to be diagnosed and treated on a 24-hour basis. Development of this Service will obviate many hospital admissions and the economic advantage is real.

## Summary and Conclusions

A Respiratory Care Service is described in terms of personnel-function or x-y schematic (Fig 8). The Service may be administered as a Division within the Department of Anesthesiology (or any department) with a Medical Director who has assistants, fellows, and residents. There are six subdivisions (services):

I. The Respiratory ICU, with a supervisor, complement of nurses, aides, orderlies, unit manager, and secretary.

II. The Inhalation Therapy Service, with a chief, assistants, therapists, and technicians.

III. The Chest Physiotherapy Service, with a chief and therapists.

IV. The Blood Gas and Pulmonary Function Laboratory, with a chief and technicians.

V. The Research and In-service Education Service, with personnel including an electronics technician and bacteriologist, and perhaps a computer technician.

VI. The Outpatient and Emergency Room Services including physician, nursing, inhalation therapy, chest physiotherapy, and laboratory personnel.

The size of the hospital and its patient mix will determine variations of these six Services. Thus, Inhalation Therapy may perform III and IV, and contribute to I and V.

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## VENEREAL DISEASE TREATMENT SCHEDULE

### General Considerations

I. **Prophylactic Treatment** — clinically negative contacts of infectious syphilis and gonorrhea patients should be treated immediately. Treat on the first visit. Do not wait for laboratory results.

A. Syphilis contacts — 2,400,000 units of Bicillin.

B. Gonorrhea contacts — According to schedule; female contacts of gonorrhea patients should be treated even when laboratory culture result is negative.

II. State Law requires that physicians report venereal disease cases to the Health Department. Communicable Disease Report Cards, letters, and telephone calls are acceptable for meeting this obligation. The Health Department does not regard a reactive or positive laboratory report as a case of venereal disease. The physician must report the case when diagnosed.

III. State Law allows physicians to examine and treat minors for venereal disease without obtaining parental consent.

IV. The Health Department **does not** contact private patients without the physician's consent.

V. When submitting specimens for examination to State Laboratories, include all requested information. Patient's **age** is especially important.

VI. Treat dual infections (usually syphilis and gonorrhea) according to schedule for each disease. Medication to be given simultaneously.

VII. Patients with reactive serologic tests for syphilis, **including** the Fluorescent Treponemal Antibody Test (FTA Test), often state that they have been treated in the military, in another state, hospital, or by another physician, etc. Unless previous adequate treatment can be verified, the Health Department recommends retreatment.

VIII. Studies show that procaine penicillin with probenecid produces a greater gonorrhea cure rate than procaine penicillin alone. Ideally, the probenecid should be given thirty (30) minutes prior to injection. However, if this time is not feasible, anytime immediately before injection is recommended.

IX. Post-gonococcal urethritis can be treated with tetracycline, 0.5 gram orally four times a day for at least seven days.

X. **Contact Interviewing** — Sexual contacts should be elicited whenever possible from the following patients:

A. All primary and secondary syphilis cases.

B. Early latent syphilis cases if duration of infection is less than one year.

C. All male gonorrhea cases.

The Health Department has trained personnel available for patient interviewing and for rapid contact follow-up.

5/4/72

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# Venereal Disease Treatment Schedule

Maryland State Department of Health and Mental Hygiene
Division of Communicable Diseases 383-2649
Venereal Disease Control Section
5/4/72

| Diagnosis | Treatment | Comments and Follow-Up |
|---|---|---|
| 1. Primary Syphilis (chancre)<br>2. Secondary Syphilis | 2,400,000 units of Benzathine Penicillin G (Bicillin) IM at a single session (1,200,000 units in each buttock) | STS at time of Rx. Repeat in 30 days; then every 3 months for a year. |
| 3. Late Syphilis | | |
| A. **Early Latent Syphilis** (Less than 2 year's duration) | | |
| 1. Nonreactive Spinal Fluid Examination | 2,400,000 units Bicillin IM at a single session (1,200,000 units in each buttock) | STS every 3 months for 1 year; then every 6 months for a year |
| 2. No Spinal Fluid Examination Done | 7,200,000 units Bicillin IM total (2,400,000 units weekly X 3) | Same as above. |
| B. **Late Latent Syphilis** (more than 2 year's duration) | | |
| 1. Nonreactive Spinal Fluid Examination | 2,400,000 units Bicillin IM at a single session (1,200,000 units in each buttock) | STS every 3 months for 1 year; then every 6 months for a year — for a total of 2 years |
| 2. No Spinal Fluid Examination Done | 7,200,000 units Bicillin IM total (2,400,000 units weekly X 3) | Same as above |
| C. Late Manifest Syphilis<br>Cardiovascular<br>Neurosyphilis<br>Other | 7,200,000 units Bicillin IM total (2,400,000 units weekly X 3) | STS every 3 months for 1 year; then every 6 months for a year. In neurosyphilis, the spinal fluid should be re-examined 6 months after treatment. |
| 4. Congenital | | |
| A. Early (Patient under 2 years old) | 50,000 units Bicillin per kg body weight in a single dose. | STS every 3 months for 1 year |
| B. Late (Patient over 2 years old) | | |
| 1. under 12 years; weight 70 lbs. or less | 1,200,000 units Bicillin IM in a single injection | STS every 3 months for 1 year; then every 6 months for a year |
| 2. 12 years or older but weight more than 70 lbs. | same as stage of late syphilis | same as stage of late syphilis |
| 5. Syphilis in Pregnancy | According to Stage | According to Stage. When in doubt treat. |
| 6. Gonorrhea (Male & Female) Uncomplicated Urethral, Cervical, Pharyngeal or Rectal<br>Note: Positive male smear is diagnostic. Smears in female are of no value | 4,800,000 units Aqueous Procaine Penicillin G, IM, with 1 gram oral probenecid given 30 minutes prior to injection OR Ampicillin 3.5 grams oral, with 1 gram oral probenecid given simultaneously | STS and Culture at time of treatment. Repeat male urethral culture 7 days after treatment. Repeat cervical and obtain female rectal culture 7-14 days after treatment. |
| **Alternate Antibiotics** (for those allergic to Penicillin, Ampicillin, or Probenecid) | | |
| Gonorrhea | Spectinomycin (Trobicin) 2 gm IM for males, 4 gm IM for females (2 gm in each buttock) OR Tetracycline 1.5 gm orally; then 0.5 gm orally 4 times a day for 4 days (9.0 gm) | STS at time of treatment. Repeat in four months if nonreactive |
| Syphilis<br>1. A. Primary and Secondary<br>B. Latent cases with nonreactive spinal fluid examination | Tetracycline 0.5 gm orally 4 times a day for 15 days (30 gm) | |
| 2. A. Late Manifest<br>B. Latent cases with no spinal fluid examination done | Tetracycline 0.5 gm orally 4 times a day for 30 days (60 gm) | |
| 7. Chancroid | Sulfonamides such as Sulfadiazine 1.0 gm qid for 7 days or Tetracycline 0.5 gm orally qid for 14 days | STS at time of treatment, then monthly for 3 months |
| 8. Granuloma Inguinale | Tetracycline orally 0.5 gm qid for 15 days | STS at time of treatment. Repeat in 4 months if nonreactive |
| 9. Lymphogranuloma Venereum | Tetracycline orally 0.5 gm qid for 10 days | STS at time of treatment. Repeat in 4 months if nonreactive |

# SIXTH ANNUAL SEMINAR
# ON THE MEDICAL ASPECTS OF SPORTS

**SATURDAY, DEC 2, 1972**
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**DIVISION OF HEALTH, PHYSICAL EDUCATION AND RECREATION**
**OF CATONSVILLE COMMUNITY COLLEGE**

**MORNING SESSION**

8:00 AM **Registration**
The Physical Development Center
Coffee and Donuts—Visit Exhibits

9:00 AM **Opening Remarks**
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Representative,
Medical and Chirurgical Faculty

9:15 AM **Anatomy and Functional Physiology of the Shoulder Joint**
Vernon E. Krahl, PhD
Professor of Anatomy
University of Maryland School of Medicine

10:00 AM **Mechanism of Injury, With Surgical and Nonsurgical Treatment of Injuries to the Shoulder Joint**
Stanford Lavine, MD
Orthopedic Surgeon, Washington, DC
Former Orthopedic Surgeon for the Washington, DC Professional Basketball Team
Chief Physician for the University of Maryland Department of Athletics

10:45 AM **Intermission—Visit Exhibits**

11:00 AM **Symposium on Conditioning and Rehabilitation of the injured Shoulder Joint**
Mr. William Neill III, RPT
Assistant Trainer, Baltimore Colts
Director, Physical Therapy
Kernan Hospital, Baltimore, Md

Ed Block, EdD, RPT
Chief Trainer, Baltimore Colts

Mr. Otho Davis, RPT
Assistant Trainer, Baltimore Colts

12:00 Noon **Lunch—Visit the Exhibits**

**AFTERNOON SESSION**

1:30 PM **Science in Sport: How to Measure and Improve Athletic Performance**
Vaughan Thomas, TC, DLC, MSc, PhD
Director of Physical Education
Liverpool Polytechnic Institute, Liverpool, England
Author of the Book by the same name, Published by Little, Brown

2:30 PM **Motivation and Communication With the High School Athlete**
Mr. Redmond C.S. Finney, BA, MEd
Headmaster, The Gilman School
Former Football Coach, The Gilman School, Baltimore, Md

3:00 PM **Motivation and Communication With the Collegiate Athlete**
Mr. Earl Banks, BS, MA
Head Football Coach
Morgan State College, Baltimore, Md.

3:30 PM **Intermission—Visit the Exhibits**

4:00 PM **Panel Discussion**

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Saturday, Dec 2, 1972

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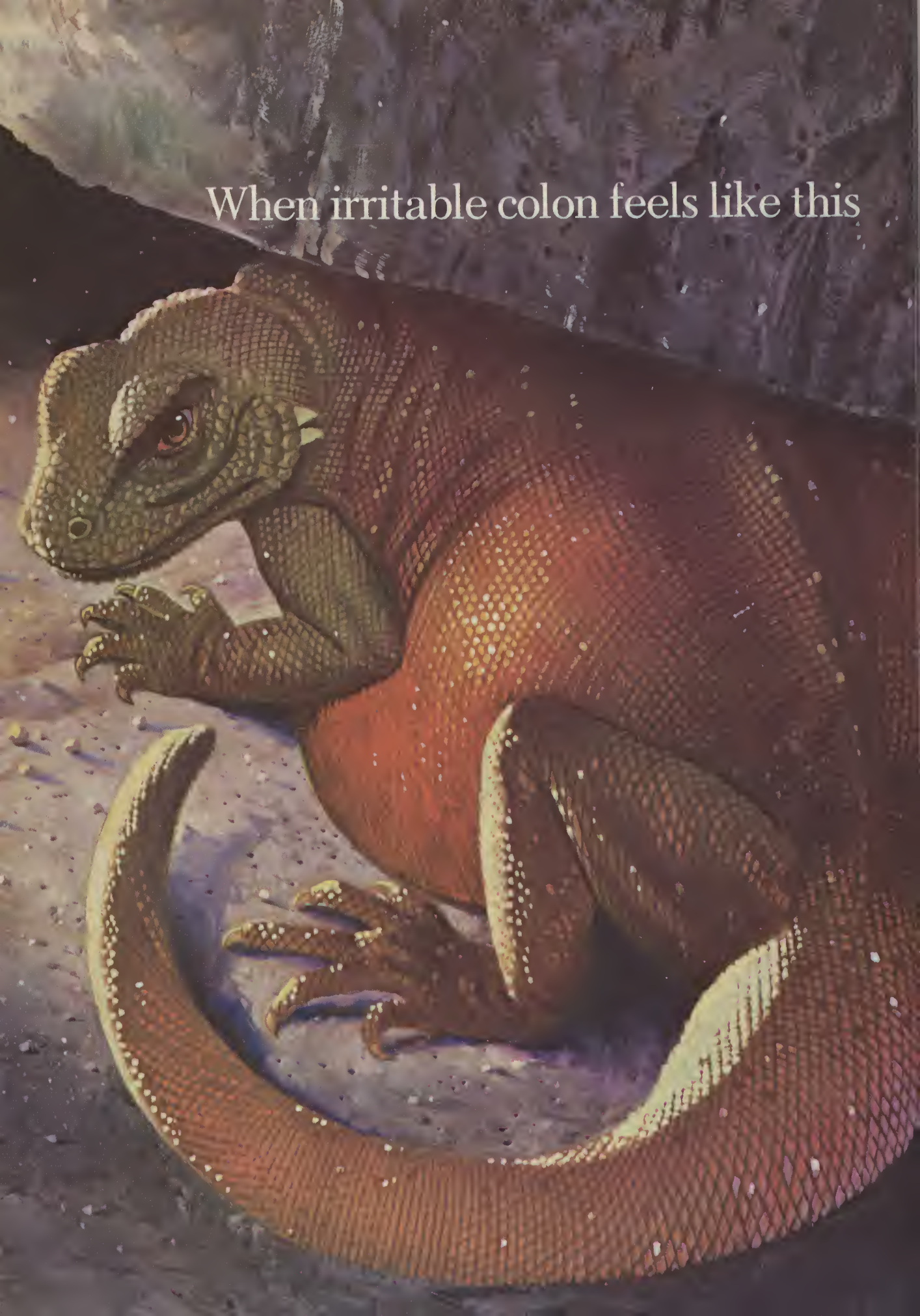
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When attempts are made to probe him
from his niche, he gulps air
until his abdomen is distended up to
sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.



DANIEL V. LINDENSTRUTH, MD, Editor

*A Service of the Heart Association of Maryland*

**the heart page**

# A PRACTICAL APPROACH TO EXTRASYSTOLES

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*Information and reprint requests to Dr. Montgomery.*

The evaluation and management of extrasystoles constitutes one of the most common and most perplexing cardiac problems in general medical practice. Sometimes, palpitation is the patient's presenting symptom, but often the premature beats are discovered incidentally in the course of an examination. The physician is then obliged to try to determine their significance and to plan their management.

Extrasystoles are potentially harmful for two main reasons: they reduce cardiac output and they may introduce sustained arrhythmias. Cardiac output is decreased primarily because of the beat's prematurity. Ventricular filling time is shortened, resulting in smaller stroke volume. Other factors such as abnormal contraction patterns following abnormal activation sequence also contribute to diminished stroke volume. It has been shown that frequent ventricular extrasystoles can actually reduce cardiac output by as much as 25%.[1] If the patient's cardiac situation is one which will not tolerate such a decrease in output, then any premature contraction may be important to him.

Extrasystoles may introduce sustained rhythm disturbances, and are more likely to do so in patients who have an increased susceptibility to arrhythmia development. This usually means an increase in myocardial irritability from ischemia, inflammation, hypoxia, or toxicity. Certain characteristics of the extrasystoles themselves may also give clues to the probability of developing a sustained arrhythmia.

With these many variables to consider, the clinician will find that a systematic approach to the patient with extrasystoles is helpful. The following is an outline of such a scheme:

I. Characteristics of the extrasystoles themselves
  A. Supraventricular
  B. Ventricular
    1) Multifocal or unifocal
    2) Repetitive
    3) Dangerously close to the peak of the preceding T wave.

II. Clinical setting
  A. Organic heart disease present or absent
    1) With congestive failure
    2) With myocardial ischemia, infarction, or inflammation
  B. Toxic factors
    1) Digitalis
    2) Quinidine
    3) Hypokalemia
    4) Anoxia

## Supraventricular Premature Beats

The simplest case will be one in which there are supraventricular premature beats with no evidence of organic heart disease and no suggestion of toxicity. Ordinarily, these extrasystoles can be ignored and the patient reassured. If the patient is unpleasantly aware of the palpitation, he should be advised to avoid those factors which may predispose to extrasystoles. They include tobacco, caffeine-containing drinks, alcoholic

drinks, and nervous tension. If the patient eliminates all these influences and still is deeply annoyed by palpitation, simple sedation may be successful. Stubborn supraventricular premature beats ordinarily should not be treated with quinidine, pronestyl, or digitalis preparations, since each of these medications introduces more potential of harmful side effects than is justified.

Supraventricular premature beats in the presence of organic heart disease may be significant, particularly if the patient's compensation is marginal enough to be threatened seriously by further fall in cardiac output. In early congestive heart failure, the extrasystoles may disappear with digitalization and management of the underlying decompensation. If there is acute myocardial infarction or acute carditis, such premature beats may be important not only because they diminish cardiac output, but also because they may herald the onset of atrial fibrillation or flutter.[2]

Digitalis may be ineffective in suppressing them or may be inappropriate since many such patients are unusually sensitive to it. In these instances, quinidine is the drug of choice. Of all the antiarrhythmic preparations, I find it the most effective against supraventricular premature beats.

Supraventricular premature beats in a patient who is receiving digitalis glycosides may be an early indication of digitalis toxicity. They will often subside if the dose is reduced or if the drug is omitted for one or two days.

### Ventricular Premature Beats

Ventricular premature beats are, on the whole, considerably more significant than supraventricular prematures. In patients without organic heart disease and without any history to suggest toxicity, they still may be important. If they are multifocal, occur repetitively, or appear close to the peak of the T wave of the preceding beat, they are more likely to presage a sustained ventricular arrhythmia than those which are unifocal, appear singly only, and are far from the apex of the T wave. Probably all ventricular premature beats should be eliminated if possible, but those more dangerous ones demand treatment more urgently.

The first approach to a healthy patient with single, unifocal prematures which are not dangerously placed should be to eliminate the usual predisposing factors (tobacco, caffeine, alcohol, and tension) adding simple sedation if necessary. The clinician should avoid using antiarrhythmic medications as long as possible in these patients, once again because of the possibility of side effects more threatening than the presence of the extrasystoles themselves.

Special consideration needs to be given to middle-aged and older patients who have more than ten ventricular premature beats per thousand beats. Such patients are more prone to die from coronary heart disease than are patients who do not have frequent premature beats.[3,4] These patients should be studied carefully for other evidence of coronary heart disease and for coronary predisposing factors such as overweight, hypertension, hyperlipidemia, etc. The extrasystoles themselves may be controlled with reassurance, omitting alcohol, tobacco, and caffeine, and adding simple sedation.

Ventricular premature beats which are dangerous (multifocal, repetitive, or placed close to the apex of the preceding T wave) should be eliminated. These beats carry a considerably higher risk of introducing ventricular tachycardia or ventricular fibrillation, and may themselves constitute the only clinical evidence of underlying organic heart disease. When they are found, a diligent search for other evidence of ischemic or inflammatory heart disease should be made along with careful elimination of any potential toxic factors. These extrasystoles are dangerous enough to warrant using long-term antiarrhythmic medication for their control. Whether the physician chooses quinidine, procaine amide, diphenylhydantoin, or propranolol will usually depend upon his experience with one or more of these drugs. Once a choice is made, its side effects should be sought at each succeeding visit with the patient.

If the resting electrocardiogram shows only a few ventricular premature beats, yet the patient complains of considerably more palpitations than these might suggest, monitoring for several hours may uncover the nature of the extrasystoles causing the palpitation. A resting electrocardiogram might show a few ventricular prematures, but the monitor may reveal runs of atrial extrasystoles when the patient feels his palpitation. The management of such a patient would be quite different from that of another patient who has only a few atrial prematures in a resting electrocardiogram, but many multifocal ventricular prematures on 12-hour monitoring.

Ventricular premature beats in the presence of organic heart disease may herald the onset of congestive heart failure and may disappear with digitalis therapy. Or, in patients with valvular heart disease even without frank congestive heart failure, ventricular premature beats may still re-

duce cardiac output below an acceptable minimum. In these instances, antiarrhythmic medication rather than digitalis may be more effective.

In those patients whose organic heart disease predisposes toward sustained arrhythmia, ventricular premature beats become quite dangerous. In acute myocardial infarction and acute myocarditis, even a single ventricular premature beat may presage the onset of ventricular tachycardia and fibrillation.[1] They should be eliminated with an appropriate antiarrhythmic preparation, utilizing lidocaine, pronestyl, or quinidine. Propranolol may be effective but must be used cautiously because of the added risk of precipitating congestive heart failure in the acutely ill patient.

Toxicity adds one more element of danger to ventricular premature beats and requires altering therapy. The most frequent is digitalis toxicity, a common cause of ventricular extrasystoles, ventricular tachycardia, and even ventricular fibrillation. Any form of the drug can produce significant arrhythmic toxicity, and any patient who takes digitalis preparations can become toxic.

Hypokalemia and toxicity with any antiarrhythmic drug can predispose to ventricular premature beats which may develop into sustained ventricular arrhythmias. Treatment in these cases will include discontinuing the offending drug or replenishing deficient potassium. Hypoxia, as during anaesthesia, also increases the potential for premature beats.

In summary, extrasystoles have varying significance and varying potential for harming the patient. In order to determine their management wisely, the physician must study their origin and characteristics, then evaluate their relationship to the clinical setting.

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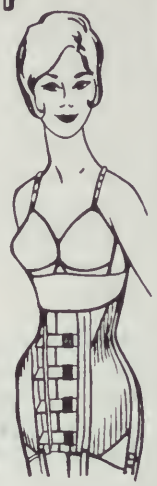

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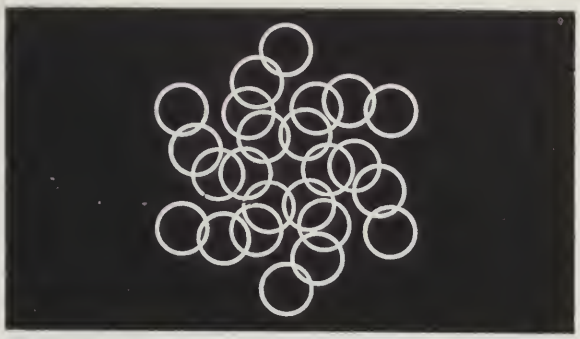
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

# THE PERSON INSIDE THE ALCOHOLIC

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*Based on a paper presented at the Second Annual Meeting, American Medical Society on Alcoholism, Baltimore, Md, October 1971.*

*Information and reprint requests to Dr. Reading.*

Describing and classifying alcoholism is a difficult enough task. Many bases of classification have been proposed, but none has proven entirely satisfactory. Describing and classifying the people who become alcoholics is equally difficult. A number of questions critical to such an enterprise still elude definite answers: What sort of people are alcoholics? What sort of people were they before? How did they get to be this way? How different are they from other people? How similar are they to each other? Is their alcoholism related to the sort of people they are? And, does it make a difference what sort of people they are?

The need to define and classify is one of the first steps of the scientific enterprise. It is the skeleton on which orderly thought is hung. Constructing conceptual systems that correspond to the realities of their subject matter is, however, no mean task. Over the years, attempts to define the personality characteristics of individuals suffering from alcoholism have met with little consensus. In particular, attempts to identify a so-called "alcoholic personality" have failed repeatedly. The difficulty may well be that no such unique set of personal characteristics exists. Certainly, to date, no set of psychosocial, psychodynamic, or personality factors has been found which is present only in alcoholics and is present in every one of them.

That is not to say that personality factors do not play a role in alcoholism. A number of personality traits have been shown to be associated with alcoholism; but their relationship is a probable, not an absolute one. Important as they may be, these traits are neither necessary nor sufficient to explain the development of alcoholism.

Human behavior is the final outcome of a number of complex determinants. At any given point in time, the individual is the product of all of his past constitutional and experiential circumstances; his behavior is the outcome of the interaction between these and his current environment. It is clearly unwise to look for the etiology of disordered behavior in any single one of these areas. All contribute to human variability, including the variability that enables one individual to drink with impunity and another to succumb to alcoholism, as well as the variability that makes one alcoholic different from another. Thus, while the sort of person an individual is may affect his susceptibility, it in no way determines his alcoholism. Dependency, for example, is a personality trait that has often been associated with alcoholism.

If his circumstances are such that his needs can be gratified otherwise, an excessively dependent individual will not become an alcoholic. On the other hand, a less dependent individual may develop alcoholism if he is continually unable to find other sources of gratification in his environment. Thus, if the determinants of alcoholism lie neither within the individual nor within his environment, but in their interaction, the primary disorder may well be a dysfunctional relationship between the two. Excessive drinking may

serve temporarily to rectify this disordered relationship. Because it fails to deal with the real problem, because it can be physiologically self-perpetuating (addictive), and because it produces a number of deleterious consequences, such excessive drinking is maladaptive. The relative contributions of personal and situational factors in the genesis of such maladaptive behavior will, however, vary from case to case.

Alcoholism is, however, but one of a number of maladaptive ways of responding to life's stresses and strains. The extent to which certain personality traits make an individual more susceptible to this particular pattern of response is not at all clear. The personality traits that have been associated with alcoholism have also been associated with a number of other behavioral, neurotic, and psychosomatic disorders. All of them are rather general personality characteristics and are present to some degree in the general population. When excessive, they represent a degree of psychosocial immaturity sufficient to burden the individual's attempts at leading a productive and satisfying adult life. The similarity of the personality characteristics in alcoholism and in these other maladaptive disorders may indicate their lack of etiological specificity.

What then are these personality features and of what importance are they? The characteristics that have been regularly identified in populations of alcoholics include a low frustration tolerance, excessive dependency needs (sometimes manifested as pseudo-independence), and underlying feelings of inferiority and self doubt. Many alcoholics are sensitive to rejection, and tend to have difficulty in entering into other than superficial social relationships because of this. They tend to use excessive amounts of denial, to be resistive to deeper psychological explanations of their condition, and to indulge in magical and unrealistic thinking about their futures. And in their histories, recurrent themes of depression, emptiness, and loneliness are often revealed.

Individual alcoholics differ widely in their manner and degree of manifesting these "typical" features. Furthermore, it is important to remember that even when they are all present, they do not represent the entirety of a given individual's personality. Despite the similarities, each alcoholic has a unique personality that must be reckoned with, especially if one is to treat him.

The management of alcoholic patients is often so fraught with difficulty that both physician and patient quit out of frustration. At times, the physician's usual patterns of dealing with patients simply do not work for the sort of people he is most likely to encounter with alcoholism. Management strategies that take into consideration the more typical personality features of the alcoholic prove much more effective. For instance, because of the possibility of the alcoholic patient having a low tolerance for frustration, the physician (or other treating person) should be careful not to place unreasonably high demands on him, particularly in the early phases of treatment. He should be willing to tolerate his dependency needs and to provide the necessary support and encouragement. The physician should realize that, because of his fears of rejection, the alcoholic patient may have relative difficulty in entering into a meaningful treatment relationship.

Indeed, before they are really able to commit themselves, some alcoholics may need to test the physician's interest by angrily provoking him and seeing how he responds. The physician needs to guard against retaliation in such cases, for this only serves to confirm the patient's suspicions. This does not mean that all of the patient's indiscretions should be tolerated. The physician should point these out to the patient without emotion or rejection; for the gradual establishment of reasonable and consistent limits is often a necessary part of treatment. Similarly, he should respect the patient's use of denial and other defense mechanisms, especially if other aspects of treatment are proceeding satisfactorily.

By tailoring his general approach to alcoholics in this way, the physician will find that he is increasingly able to prevent sudden and premature termination of the treatment relationship. Such strategies give him a means of bridging the gap until the patient is willing to reveal the more particular aspects of his case. But there are limitations to such general approaches. For while they help support and motivate the patient, they do not directly address themselves to remedying the causes of his drinking. Dealing with all alcoholics in the same way, no matter how successfully, ultimately fails to deal with any of them. This dilemma highlights the distinction between psychological management and treatment.

Psychological treatment differs from other forms of medical treatment in that it deals with a different order of biological complexity. If you have pneumonia, it doesn't really matter what sort of person you are, the penicillin is equally likely to be effective. In much the same way, the treatment of the medical complications of alcoholism is based on considerations which are independent of the sort of person the patient

is. But in the treatment of the "alcoholism" itself, attention to the particular person is critical. It is the person himself, and not the condition from which he suffers, that is the subject of treatment. All psychological treatment ultimately has to deal with the unique and individual factors that make the patient the sort of person he is.

This is not really that dissimilar from other forms of medical treatment. Just as one treats cirrhosis by attending to the underlying liver dysfunction, one treats alcoholism by attending to the underlying personal dysfunction. The general personality features associated with alcoholism serve only as a first approximation in this process. As the physician becomes more familiar with the patient, he must let his inquiry lead him to an understanding of the particular factors that prompt and maintain his excessive alcohol consumption. Once he begins to understand these specifics, the physician can help the patient understand them and begin to deal with them more appropriately. This, of course, is the crux of treatment.

Thus, while treating all alcoholics as if they were alike is convenient for some purposes, it poses a serious obstacle to effective treatment. It is, unfortunately, an all-too-common practice perpetuated both by people in the field of alcoholism and by those outside of it. Stereotyping serves to relieve us from having to come to terms with other people as individuals. It is the basis of prejudice. Failure to distinguish between members of a class can, however, be just as prejudicial as discriminating against them. Each of these forms of prejudice helps maintain the other. While, in recent years, much energy has been placed in campaigns to deal with discrimination against persons with alcoholism, much less attention has been paid to the problems caused by failure to discriminate between them. Recognizing the ways in which one alcoholic patient differs from another is as important as recognizing the ways in which they resemble each other. Knowledge of both is necessary if one is going to work with the person inside the alcoholic in helping him to do something about his alcoholism.

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# SEMIANNUAL REPORTS TO THE HOUSE OF DELEGATES SEPTEMBER 15, 1972

## BYLAWS COMMITTEE

*Mr. President and Members of the House of Delegates:*

Your Bylaws Committee met on Wednesday, July 19, 1972 to consider various items pending before it. The following two Bylaws amendments are offered to the House for its consideration:

1. Amend Article XI (Mediation Committee), Section 14 by striking out the words "Mediation Committee" and inserting the words "Physician-Patient Relations Committee."

EXPLANATION: This amendment would clarify the activities performed by the Mediation Committee. At present, besides establishing ethical policies on behalf of the Faculty, the committee also handles differences between physician and patient, when these are either unresolved at the local level or when the component society requests the Faculty's committee to do so.

2. Amend Article VI (House of Delegates), Section 5 by inserting after subsection (b) the following new subsection (c) (subsequent subsections being automatically relettered: "(c) Two delegates without vote from each of the two medical schools in Maryland (Johns Hopkins University School of Medicine and the University of Maryland School of Medicine) to be selected by the students or their elected student representatives, one from the junior class and one from the senior class."

EXPLANATION: This amendment to the Bylaws will provide medical students from both the Johns Hopkins Medical School and the University of Maryland Medical School with representation in the House of Delegates. We have deliberately left the method of selection of these delegates to the students themselves, who can use any mechanism they feel desirable to accomplish this.

At the Bylaws Committee session, lengthy discussion took place with respect to providing such representatives a vote in the House, as well as all other privileges. It was deemed desirable that, at the present time, representation be without vote. Reasons behind this include: 1) Associate members in the Faculty numbering about 338 do not have a vote in determining Faculty business and to grant nonmembers such as students this privilege without payment of dues would not be fair; and 2) four medical student votes in the House would not, except on rare occasions, make that much difference in policy decisions reached by the House.

Other matters considered by the Bylaws Committee included representation of House staff in the House of Delegates. At present, there is no established organization with which the Faculty can deal. The Bylaws Committee was told at its meeting that a session is scheduled for October of this year when some of these issues will be clarified. John Mather, MD, a University Hospital resident, will attend this meeting and will report back to the Bylaws Committee in November. A further report will be made to the House at the Annual Faculty meeting.

Another discussion, on which the Bylaws Committee took no action, dealt with a change in the eligibility requirement for Physicians Defense. When a member pays his dues after January 31 of any year, he is denied such defense for the entire year. It is alleged this is unconstitutional. Faculty legal counsel states this is not so and your Bylaws Committee does not recommend any change in this bylaw at this time.

The Bylaws Committee also deferred taking any action in connection with a request from podiatrists for Associate Membership in the Faculty; and requested the Executive Committee to open negotiations with the Baltimore City Dental Society for an increase in Associate Membership Dues for members of this group.

The last change made was in 1963, wnen dues were increased from $2.50 per year to $5.00 per year. It is felt that dues for this group should be doubled simply because of the inflationary factors that have taken place in the last decade. Membership dues are not subject to price controls.

Respectfully submitted,

CHARLES F. O'DONNELL, MD, Chairman
VINCENT J. FIOCCO, JR., MD
JOHN F. SCHAEFER, MD
WILLIAM G. SPEED III, MD

## DELEGATES TO THE AMA HOUSE OF DELEGATES JUNE 18-22, 1972 SAN FRANCISCO

*Mr. President and Members of the House of Delegates:*

All three Delegates and three Alternate Delegates, in addition to the Faculty's President and Executive Director attended the San Francisco meeting of the AMA House of Delegates held from June 18-22. This contingent of personnel enabled each Reference Committee hearing to be covered in full and provided a unique opportunity for an exchange of the tenor of each Reference Committee session. This enabled the Delegates sitting in the House to be fully informed and briefed on the various reports as they were presented to the House and understand in a more intelligent manner the reasoning behind such recommendations. The Maryland delegation's resolution was introduced, as instructed by the Faculty's House of Delegates, and was considered at some length by the Committee. Certain information was revealed at the hearing which included the following:

- Any beneficial action on behalf of self-employed physicians which can be undertaken lawfully by a "union" or a "guild" can also be undertaken lawfully by a medical society or association.

- Regardless of the merits of collective bargaining or class actions as measures for the protection of the rights of physicians, the availability of such procedures does not depend upon the name or the organizational structure of an organization representing physicians.

- Whether an organization calls itself a union or an association, it is nevertheless subject to the Sherman Antitrust Act. Unions, as well as Associations, have been held to be in violation of the Sherman Act by the courts in particular situations. In the case of a "labor dispute," however, the Clayton Act and the Norris-LaGuardia Act

provide an exclusion from the Sherman Act, irrespective of whether the organization is a labor union or a professional association. A labor dispute is a controvery between disputants over terms and conditions of employment.

• Whatever a "union" or "guild" can do lawfully in relation to a class action, a medical society or association can also do lawfully.

The resolution was referred to the Board of Trustees for study by appropriate committees or councils of the AMA.

The House took the following other actions of interest:

### Opinion Poll

The House received, and adopted, results of the first membership opinion poll on critical issues affecting the practice of medicine. The overwhelming majority of 94,000 respondents (73.1%) recommended that AMA continue to seek to retain the basic principles of private practice in any government-enacted health program. And more than half (55.7%) preferred the AMA plan of national health insurance over all others. The AMA plan was four times as acceptable as the next most preferable option, which was catastrophic coverage, only (14.1%). If compulsory health insurance were adopted, 28.1% of respondents said they would continue private practice "with those patients who would pay my private fees" and 24.6% said they would "join the federal program and continue to practice under it." Many (21.6%) were undecided as to what they would do.

On the work of the Association, programs which received the greatest percentage of responses indicating "not enough" emphasis were communications to the public (62.5%), practice management problems (39.8%), and socioeconomic issues (35.1%). A majority of members indicated AMA was placing "proper" emphasis on scientific activities (66.3%), medical education (67.9%), continuing education (63.3%), membership benefits (51.8%), and communication to the medical profession (55.2%).

The questionnaire went to 177,882 nonfederally employed members and 94,035, or 52.9%, questionnaires were returned. The questionnaire also was sent to a random sample of 4,500 members, including federal physicians, and a random sample of 3,000 nonmembers of the AMA to test sampling techniques as a possible tool for use in future surveys.

### Physicians' Assistants

Reflecting concern for "potential problems which could arise," the House approved a policy opposing employment of physicians' assistants in hospitals. The move was recommended by the Council on Health Manpower and the Board of Trustees, through Board Report B. "The Council believes that direct responsibility to and supervision by a physician is a critical element in the safe and effective performance of a physician's assistant," the report said. To the report's recommendation that an assistant "not function in that capacity when an employee of and paid by a hospital," the House added—"or (employed) by a full-time, salaried, hospital-based physician."

Also adopted was Board Report Z, proposing guidelines for compensating physicians for services of physicians' assistants. It urged legislation to empower state boards of medical examiners to approve a physician's employment of an assistant and to approve proposed functions of the assistant, as described by his employer. Reimbursement for assistant's services should be made directly to the employing physician, the report said.

Report Z was amended by adding (at the end of line 21, page 2): "The term physician's assistant as used refers solely to new occupations being developed to assist the physician in delivery of personal care services, and not to such existing or established occupations as the medical office assistant."

### Allied Personnel

Also adopted was Board Report F, dealing with education and utilization of allied health manpower. Some of its recommendations urged AMA to:

1) Continue to support efforts to increase the number and improve the utilization of medical, nursing, and allied personnel until 1975, with re-evaluation then on the need for further efforts.

2) Continue to support improvement of the professional and financial potential of allied health careers.

3) Continue efforts to expand allied health career opportunities for minority and disadvantaged groups.

4) Strongly reaffirm support of an expanded role for the nurse in providing patient care, and study the nurse's role in relation to the physician assistant, so the two professions can complement rather than duplicate one another.

### Graduate Medical Education

In a major step, the House approved Report H of the Board, which establishes a Liaison Committee on Graduate Medical Education and a Coordinating Council on Medical Education.

The panels will include representatives of the AMA, Association of American Medical Colleges, Council of Medical Specialty Societies, American Hospital Association, the public, and the federal government. The House decreed, in an amendment, that AMA's four representatives to the Committee will be appointed by and from the Council on Medical Education, and the three Council representatives elected by the House, with the first election at the 1972 Clinical Convention. Continuing a spirit of recognition for young physicians and medical students, the House also added this amendment (line 38, Reference Committee C report):

"As soon as feasible after formation of the Committee and Council, AMA representatives (will) institute negotiations to provide representation from interns and residents on the Committee, and from interns, residents and medical students on the Council."

### Marihuana

The House refused to accept the statement in Board Report J which said "possession of marihuana for personal use and transfer (not sale) of insignificant amounts should not be criminal acts." After extensive debate, this substitute recommendation was adopted:

"This AMA House of Delegates does not condone the production, sale or use of marihuana. It does, however, recommend that the personal possession of insignificant amounts be considered at most a misdemeanor with commensurate penalties applied."

The substitute recommendation continued (in agreement with the original): "(The House) also recommends its prohibition for public use; and that a plea of marihuana intoxication should not be a defense in any criminal proceeding."

### Fee Determinations

Delegates approved a strong resolution aimed at any independent determination of customary physicians' fees:

"Resolved, that where benefits include physicians' fees, management, labor and third-party carriers shall consult with duly constituted representatives of organized medicine before determining 'usual, customary and reasonable fees'," the measure said.

The resolution was adopted in lieu of several others, all protesting actions of Aetna Life and Casualty Insurance Company. It added:

"The medical profession will not condone or tolerate action on the part of any third party that would encourage or promulgate litigation in the settlement of any such dispute." This referred to a practice of telling policy holders that—except where there was prior agreement between patient and physician as to the fee—the insurance company would pay the patient's legal costs if the physician sued to collect his full fee.

The resolution also reminds physicians "that they have the right to enter into prior agreement with patients regarding the fee for services to be rendered."

### Executive Vice President's Report

The House commended Ernest B. Howard, MD, AMA executive vice president, and AMA employes "for a job well done," in adopting Dr. Howard's report. The report outlines the extensive activities of the Association, ranging from answering 50,000 requests for help and information from the public each year, to sponsoring, 1,100 scientific lectures and exhibits.

### Medical Students

Bylaws changes which give medical students membership in the AMA and representation in the House of Delegates were approved by the House. A new class of direct membership for students was created, as was done previously for interns and residents. Such membership is available to members in good standing of the Student American Medical Association, or upon application with endorsement of two regular members of the AMA on the faculty of the student's school, provided there is no disapproval of membership by the Judicial Council. Students will elect their delegate and alternate delegate at a business meeting the day before each annual convention opens, with delegates to serve until the next annual session. Student dues are to be decided later by the House.

### Conventions

Although delegates were prepared for lively and extensive debate on Board Report L, dealing with conventions, it failed to develop. The report, among other things, would have switched the 1975 annual meeting from Atlantic City to Dallas.

But the House reaffirmed Atlantic City for 1975, and Dallas for the 1976 annual. The House referred to the Council on Long Range Planning and Development a recommendation that House meetings and scientific assemblies be held at different times and places.

### Smoking

To the accompaniment of several hacking coughs, delegates voted to "discourage smoking during sessions of the House." One delegate unsuccessfully invited others to "butt out" of smokers' business. On the vote, however, Vice Speaker Walker announced that "Speaker Roth and I, both being smokers, reluctantly agree that the ayes have it."

### Group Disability

The House approved acceptance of a new contract with the Fireman's Fund Insurance Company to continue the AMA Group Disability Insurance Program (Board Report M). The contract is to run five years, ending Sept 1, 1977, although the program is not guaranteed beyond Sept 1, 1974. There will be no increase in premium, but benefits will be reduced by 50% from age 65 through 69, and an additional 50% at age 70, remaining at that level for life. The amount of benefits payable for accidents will be reduced the same as sickness benefits. The Board said Fireman's Fund insisted on the change and that no alternate carrier could be found.

### Association and House Matters

Several proposals dealing with AMA structure and delegate representation and terms of office were considered. The House adopted a resolution endorsing preservation of the AMA as a federation of constituent and state medical associations, with proportionate representation as at present. It also directed the Council on Long Range Planning and Development "to consider and explore any and all methods whereby medical specialty societies and other medical organizations may have more input into the AMA . . ." The question of geographic representation on the Board of Trustees also was referred to the Council, with instructions to report back no later than the next annual meeting. On a proposal that trustees be limited to one six-year term, the House voted to ballot on the matter at the 1972 clinical meeting. The ballot will contain four choices for trustee terms: 3-year term, maximum three terms, as at present; 3-year term, maximum two terms; 4-year term, maximum two terms; and 6-year term, maximum one term.

Resolutions must be submitted to Headquarters no later than 30 days prior to opening of the session at which it is to be considered, the House decreed. However, a constituent society whose House adjourns during, or one week before, the 30-day period is allowed seven days after its meeting ends to submit resolutions.

### Miscellaneous

The House adopted Board Report E, which says: "Insurance carriers should be urged to provide nondiscriminatory coverage for alcoholism and drug dependence."

The Interspecialty Committee was elevated to the status of Interspecialty Council. Since the committee's establishment in 1966, Board Report O said, it has enabled representatives of specialty groups "to confer and exchange ideas on major issues confronting medicine, and has enabled the specialty societies to participate in the formulation of AMA policy decisions."

Essentials of approved educational programs for urologic physicians' assistants, respiratory therapy technician and respiratory therapist, and for medical assistants in pediatrics were adopted.

Respectfully submitted,

ROBERT vanL. CAMPBELL, MD
CHARLES F. O'DONNELL, MD
RUSSELL S. FISHER, MD
M. McKENDREE BOYER, MD, Senior Alternate

## REFERENCE COMMITTEE

*Mr. President and Members of the House of Delegates*:

There was only one resolution introduced prior to the July 21, 1972 deadline for submission of resolutions for consideration by the House. Inasmuch as this resolution did not appear to be controversial, it was deemed not necessary to hold a Reference Committee hearing on it.

The Reference Committee was polled and agreed to ask the House to adopt this resolution by unanimous vote. It reads as follows:

Whereas, On April 15, 1897 there did meet at the Grange Hall, Towson, Maryland, 18 physicians then practicing the noble art of medicine in Baltimore County; and

Whereas, They did proceed with energy, dispatch and concord to devise a working constitution, adopt it, elect officers, and establish the time and place of the next meeting; and

Whereas, Soon thereafter, 45 physicians did confirm

these actions by affixing their signatures to said constitution; and

Whereas, This Association, named the Baltimore County Medical Association, has maintained its existence and its purposes to this day, altered only by the prudence of incorporation in 1952; and

Whereas, Baltimore County Medical Association, Inc., has achieved a lusty, vital and active 75 years of age; therefore, be it

*Resolved,* That this Assembly notes these achievements, encourages the extension of its plans and congratulates it on its longevity; and be it further

*Resolved,* That this resolution with its enclosed addenda, a facsimile* of the original meeting notes and signatures of the 45 original Committee members, be made part of the minutes of the House of Delegates session, Friday, Sept 15, 1972.

HERBERT H. LEIGHTON, MD, Chairman
MELVIN B. DAVIS, MD
ANDREW C. MITCHELL
MARVIN I. MONES, MD
LOUIS R. RANDALL, MD

** A transcription, to the best of the editor's ability, follows.*

Towson, April 15, 1897

On April 1st 1897 an invitation to the physicians of Baltimore County was issued by Drs. Jackson Piper, Towson; J. F. H. Gorsuch, Fork; R. C. Massenburg, Towson; R. Percy Smith, Sunnybrook; H. Burton Stevenson, Rider, requesting all physicians in the County to meet them at Grange Hall, Towson, April 15th 1897 at 2 PM for the purpose of forming a county medical society.

In response to the invitation, the following physicians met at the above place & date. Jackson Piper, R. C. Massenburg, J. H. Jarrett of Towson, E. N. Brush, Sheppard Asylum, J. F. H. Gorsuch, Fork, H. Burton Stevenson, Rider, T. C. Peebles, Lutherville, Wm. J. Todd, Mt. Washington, R. Percy Smith, Sunnybrook, Wm. Lee, Stevenson, Chas. G. Hill, Arlington, J. E. Benson, R. B. Benson, Cockeysville, E. G. Darling, Lauraville, J. L. Ridgeley, Rockdale, P. F. Sappington, Govanstown & L. Gibbons Smart, Roland Park. (18)

Dr. Stevenson called the meeting to order, explained its object & placed in nomination as Temporary Chairman Dr. Jackson Piper, who was elected. Dr. L. G. Smart was elected Temporary Secretary. Drs. Massenburg, Lee, Todd, Brush, & Gorsuch expressed their views as to the wisdom of forming a county medical society.

A motion was made by Dr. Lee to appoint a committee of three to draft a Constitution & Bylaws. Dr. Smart offered an amendment to make the committee five instead of three, it was seconded & amendment carried. The Chair appointed Drs. Stevenson, Peebles, Brush, R. Percy Smith & Massenburg, which committee retired.

Dr. Todd spoke of the business side of medical societies.

After an interval of some minutes the committee appeared with Constitution & ByLaws. Before reading of it, a motion was made by Dr. Brush the same committee retire after adoption of Constitution to name permanent officers.

The Constitution & ByLaws as drafted by the Committee was then read by Dr. Stevenson, the Chairman, after which it was read by sections, amended or altered by the Association. Art. 1 Sec. 1 of the adopted Constitution provides that this socicy be known as "The Baltimore County Medical Association".

After the Constitution & ByLaws were completed to the satisfaction of the Association, the Committee again retired to name officers. Dr. Brush having left, Dr. Lee was appointed in his place on the Committee, which after consultation reported permanent officers as follows—President, Jackson Piper. Vice President, Wm. Lee. Secretary, L. Gibbons Smart. Treasurer Wm. J. Todd. Executive Committee—R. C. Massenburg, T. C. Peebles, H. B. Stevenson.

Committee of Honor—Chas. G. Hill, J. F. H. Gorsuch, R. Percy Smith. All were unanimously elected for one year. On motion of Dr. Stevenson, the Secretary was instructed to notify every member of the medical profession in Baltimore County of the time & place of next meeting & invite them to be present.

The Treasurer & Secreary were instructed to purchase what books they needed & have done whatever printing was necessary.

At a late hour the Association adjourned to meet in Towson on the 3rd Thursday in May.

/s/ L. GIBBONS SMART
Secretary

We the undersigned approve and agree to abide by the foregoing Constitution and ByLaws of the Baltimore County Medical Association.

Jackson Piper, Towson
William Lee Stevenson, Station
L. Gibbons Smart, Roland Park
William J. Todd, Mt. Washington
R. C. Massenburg, Towson
H. Burton Stevenson, Rider
R. Percy Smith, Sunnybrook
Edward N. Brush, Sheppard Asylum
Edwin E. Jones, Arlington
T. C. Peebles, Lutherville
Chas. M. Franklin, Sheppard Asylum
Purnell F. Sappington, Govanstown
J. E. Benson, Cockeysville
B. R. Benson, Cockeysville
J. Percy Wade, Catonsville
(Illegible Name) , Catonsville
J. Clement Clark, Catonsville
Arthur Hawkins, Catonsville
Hube Richardson, Mt. Hope
Charles L. Mallfeldt, Catonsville
Jas. L. Ridgeley, Rockdale
Charles G. Hill, Arlington
H. S. Jarrett, Towson
H. Y. Harrison, Loch Raven
Wm. R. Dunton, Jr., Sheppard Asylum
A. R. Mitchell, Hereford
John R. Winslow, Roland Park
J. H. Jarrett, Towson
B. F. Bussey
H. Louis Naylor, Pikesville
W. B. Hall, Mt. Misons
Jas. F. H. Gorsuch, Fork, Md.
W. P. E. Myse, Pikesville, Md.
B. Whiteley, Catonsville, Md.
G. S. Thompson, Phoenix, Md.
Thomas C. Bussey, Texas, Md.
Earl Duncan, Govanstown, Md.
Lewis H. Gundry, Irvington, Md.
Thomas B. Owings, Ellicott City, Md.
Frank R. Rich, Towson, Md.
Alfred L. Gundry, Catonsville
John R. Reuchel, Catonsville, Md.
Wm. A. Boyd, Govans, Md.
J. Smith Linthicum, 807 Park Ave., Balto
Geo. B. Wolff, S. and E. P. Hosp, Towson, Md.

# MINUTES

## Semiannual Session, House of Delegates

## (276th Meeting)

## Medical and Chirurgical Faculty of the State of Maryland

## Friday, Sept. 15, 1972

## Ocean City Convention Hall, Ocean City, Md

The 276th meeting of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:45 AM on Friday, Sept. 15, 1972, at the Ocean City Convention Hall, Ocean City, Md, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors:

Manning W. Alden, Council
William A. Andersen, Baltimore Co.
Charles Bagley III, Wicomico Co.
Timothy D. Baker, Baltimore City
John C. Ball, Council
George S. Banning Jr, Pr. Geo. Co.
Richard D. Bauer, Past President
Francis J. Borges, Baltimore City
Katherine H. Borkovich, Council
M. McKendree Boyer, Council
James B. Brooks, Council
Henry A. Briele, Past President
Robert vL. Campbell, Council
D. Delmas Caples, Baltimore Co.
John T. Chissell, Council
*Thomas Cimonetti, Howard County
Arthur E. Cocco, Baltimore City
Edward F. Cotter, Baltimore City
Joseph R. Cowen, Baltimore City
Kenneth Cruze, Montgomery County
William B. Culwell, Carroll County
*Raymond C. Cunningham, Baltimore City
Richard Y. Dalrymple, Council
Henry V. Davis, Cecil County
Melvin B. Davis, Baltimore County
Matthew Debnskey, Baltimore City
DeWitt F. DeLawter, Council
S. J. Demarco III, Baltimore City
*Frederick Young Donn, Mont. Co.
William Carl Ebeling, Council
Wolcott L. Etienne, Council
*Reinaldo A. Faget, Dorchester County
Robert W. Farr, Kent County
Elliott R. Fishel, Baltimore City
Russell S. Fisher, Council
*William E. Gilmore, Baltimore City
*Harold H. Gist, Washington County
Robert B. Goldstein, Council
Edward G. Grau, Baltimore County
George H. Greenstein, Baltimore City

Doctors:

Wilson Grubb, Baltimore City
Thomas Franklyn Herbert, Howard County
Philip W. Heuman, Council
Charles Earl Hill, Anne Arundel County
Alfred E. Ivantsch, Baltimore County
J. Parran Jarboe, Council
Page C. Jett, Calvert County
*Bernard S. Karpers Jr, Baltimore City
*Frank J. Kasek Jr, Baltimore County
Seruch T. Kimble, Council
Howard F. Kinnamon, Past President
*Marvin L. Kolkin, Montgomery County
C. Rodney Layton, Queen Anne County
*Leon A. Levitsky, Prince George County
J. Richard Lilly, Prince George County
Elmer G. Linhardt, Council, Bd. of Med. Ex.
Francis C. Mayle Jr, Montgomery County
Karl F. Mech, Council
Donald W. Mintzer, Baltimore City
Andrew C. Mitchell, Wicomico County
Marvin I. Mones, Montgomery County
*Paul A. Mullan, Baltimore City
*Joseph A. Murgalo, Prince Geo. Co.
Frederick E. Musser, Comcil
Charles F. O'Donnell, Council
Hilary T. O'Herlihy, Anne Arundel Co.
Stephen K. Padussis, Council
William A. Pillsbnry, Council
M. C. Porterfield, Carroll County
William F. Renner, Baltimore City
James A. Roberts, Montgomery Co.
William Roemmich, Baltimore Co.
Edwin Ruzicka, Council
Peter Santucci, Montgomery Comnty
*Henry C. Scruggs, Montgomery County
Margaret Lee Sherrard, Balto. Co.
R. Kennedy Skipton, Prince Geo. Co.
George I. Smith Jr, Frederick Co.
Gordon M. Smith, Montgomery County
Roland T. Smoot, Baltimore City
Aaron C. Sollod, Baltimore City
William G. Speed III, Council
George R. Spence, Montgomery County
*Charles C. Spencer, Washington Co.
Raymond P. Srsic, Anne Arundel Co.
Robert J. Thomas, Council
Francis J. Townsend Jr, Council
Richard F. Tyson, Baltimore City
Thomas E. Van Metre Jr, Baltimore City
*Hewitt I. Varney, Montgomery County
Sidney J. Venable, Baltimore County

Doctors:

Hugh W. Ward, Calvert County
H. Leonard Warres, Baltimore City
William C. Weintraub, Prince George Co.
Merton L. White, Montgomery County
*Thomas M. Wilson, Montgomery County
Charles E. Wright, Frederick County
R. Lane Wroth, Talbot County
N. Louise Young, Baltimore City
*Albert M. Zelna, Montgomery County

Present also were staff personnel.

### Invocation

Karl F. Mech, MD, Treasurer of the Faculty, gave the invocation.

### Announcements

The President made announcements dealing with the conduct of the business at the session.

### Introduction of New Members

The President introduced the following new members of the House:

| | |
|---|---|
| Katherine H. Borkovich, Baltimore | Council |
| William Carl Ebeling, Towson | Council |
| Elmer G. Linhardt, Annapolis | Council |
| Frederick E. Musser, College Park | Council |
| Stephen K. Padussis, Baltimore | Council |
| Carolyn Pincock, Silver Spring | Council |
| Edwin H. Ruzicka, Easton | Council |

### Minutes of Annual Session

The minutes of the two meetings of the House of Delegates held May 3, 1972, having been distributed to all members and having been approved by the Executive Committee, were presented to the House for information.

### Emeritus Members

On motion of the Council Chairman, Manning W. Alden, MD, the following members who had received the recommendation of their component societies and the Council were elected to Emeritus Membership in the Faculty:

Baltimore City:
Walter A. Anderson, MD
William L. Garlick, MD
Florence I. Mahoney, MD

Harford County:
Frederick O. Hodous, MD, Edgewood

### Maryland Foundation For Health Care, Election of Directors

On motion of the Executive Committee Chairman, Dr. Alden, the following nominees were submitted to the House for election as Directors of the Maryland Foundation for Health Care:

| | |
|---|---|
| Arthur E. Cocco, MD, Baltimore | 1974 |
| Katherine H. Borkovich, MD, Baltimore | 1975 |
| Earl C. Clay Jr, MD, Columbia | 1973 |
| Clifford L. Culp, MD, Annapolis | 1975 |
| John R. Davis, MD, Baltimore | 1974 |
| Leeds E. Katzen, MD, Baltimore | 1973 |
| Watson P. Kime, MD, Baltimore | 1973 |
| Harry F. Klinefelter, MD, Baltimore | 1974 |
| Edward J. Kowalewski, MD, Baltimore | 1975 |
| Charles H. Ligon, MD, Sandy Spring | 1974 |
| Alan C. Woods, MD, Baltimore | 1973 |
| Manning W. Alden, MD, Annapolis | 1973 |

W. Kenneth Cruze, MD, Montgomery County, was nominated from the floor but this nomination was subsequently withdrawn when the President stated that he would designate Dr. Cruze as one of the six Directors who are appointed by the President. The nominees proposed by the Executive Committee were thereupon elected.

### Bylaws Committee Report

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf moved the adoption of the following Bylaw amendments, which, after debate, were adopted in each case by more than the required two thirds vote:

(a) Amend Article XI (Mediation Committee), Section 14 by striking out words "Mediation Committee" and inserting the words "Physician-Patient Relations Committee."

By unanimous consent it was ordered that the section, due to the change of the name of this committee, be placed in its proper alphabetical order among the committees listed in Article XI.

(b) Amend Article VI (House of Delegates), Section 5 by inserting after subsection (b) the following new subsection (c) (subsequent subsections being automatically relettered):

"(c) Two delegates without vote from each of the two medical schools in Maryland (Johns Hopkins University School of Medicine and the University of Maryland School of Medicine) to be selected by the students or their elected student representatives, one from the junior class and one from the senior class."

A motion was made to strike out the words "without vote"; but such an amendment was ruled out of order by the President, because it was beyond the scope of the notice of the amendment given to members of the House.

### 1971 Audit Report

Karl F. Mech, MD, Treasurer, presented the auditor's statement for the year 1971. There being no objection, the auditor's statement was approved.

### Information 1971 Committee Reports

The following 1971 Committee Reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions or comments.

Report of the Delegates to the American Medical Association—Robert vL. Campbell, MD, Russell S. Fisher, MD, Charles F. O'Donnell, MD, Annual Meeting 1971, Clinical Meeting 1971.

Executive Director—Mr. John Sargeant

Library and History Committee and Finney Fund Committee—Paul F. Guerin, MD, and William H. M. Finney, MD

Curator—Edwin David Weinberg, MD

Editorial Board, Maryland State Medical Journal—C. Thomas Flotte, MD

Ad Hoc Committee on New Faculty Building—Russell S. Fisher, MD, Chairman

Committee on Emotional Health—Louis W. Tinnin, MD

Finance Committee—Karl F. Mech, MD

HAVES Program—Karl M. Green, MD, President (Hearing and Vision Early Screening Program)

Maryland Blue Shield Inc., Board of Trustees—Charles F. O'Donnell, Chairman

Med-Chi Insurance Trust—Paul F. Guerin, MD

Legislative Committee—B. Martin Middleton, MD

Liaison Committee—James B. Brooks, MD

Mediation Committee—Louis J. Kolodner, MD

Continuing Medical Education—Gerard A. Church, MD

Medical Economics Committee—W. Kenneth Mansfield, MD

Medicine and Religion Committee—Archie R. Cohen, MD

Medicolegal Committee—Howard F. Kinnamon, MD

Maryland Medical Political Action Committee—DeWitt E. DeLawter, MD, Chairman

Commission on Medical Discipline—John M. Dennis, MD, Chairman

Board of Medical Examiners—Elmer G. Linhardt, MD, Secretary-Treasurer

Occupational and Environmental Health—Carlos Villafana, MD

Peer Review Committee—Arthur E. Cocco, MD, Chairman

Dr. Cocco offered an amendment to the printed reports, correcting them as follows:

A summary of physicians reviewed since the inception of the committee is presented as follows:

| | |
|---|---|
| Total cases closed | 202 |
| Total cases pending | 50 |
| Total new cases | 38 |

There being no objection, this amendment was ordered adopted.

Policy and Planning Committee—Arthur T. Keefe Jr, MD

Committee on Preventive Medicine and Public Health —Robert E. Farber, MD

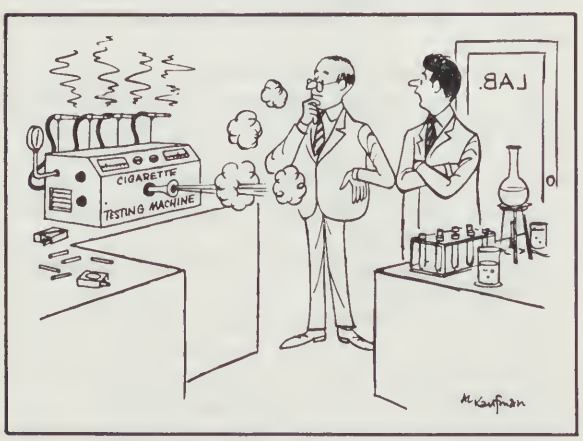
Professional Medical Services Committee—Morris J. Wizenberg, MD

Committee on Program and Arrangements— John B. De Hoff, MD

Public Relations Committee—Paul A. Mullan, MD

Secretary—William A. Pillsbury, MD

Woman's Auxiliary to the Medical and Chirurgical Faculty Report—Mrs. Robert A. Reiter




"We finished all the tests weeks ago, but it just won't quit!"

### Reference Committee Report
### Resolution 1S/72 Adopted Unanimously

Melvin B. Davis, MD, on behalf of the Reference Committee, recommended that Resolution 1S/72 be adopted. The President, inasmuch as this is a complimentary resolution and there being no objection, declared the resolution adopted unanimously. It reads as follows:

WHEREAS, On April 15, 1897, there did meet at the Grange Hall, Towson, Maryland, 18 physicians then practicing the noble art of medicine in Baltimore County; and

WHEREAS, They did proceed with energy, dispatch and concord to devise a working constitution, adopt it, elect officers and establish the time and place of the next meeting; and

WHEREAS, Soon thereafter, 45 physicians did confirm these actions by affixing their signatures to said constitution; and

WHEREAS, This association, named the Baltimore County Medical Association, has maintained its existence and its purposes to this day, altered only by the prudence of incorporation in 1952; and

WHEREAS, Baltimore County Medical Association, Inc., has achieved a lusty, vital and active 75 years of age; therefore, be it

*Resolved*, That this Assembly notes these achievements, encourages the extension of its plans and congratulates it on its longevity; and be it further

*Resolved*, That this resolution with its enclosed addenda, a facsimile of the original meeting notes and signatures of the 45 original committee members, be made part of the minutes of the House of Delegates session, Friday, Sept 15, 1972.

(The facsimile is attached only to the House of Delegates minutes contained in the minute book held at the Faculty Office.)

### Continuing Medical Education Requirements

A question was asked of the House for clarification of the Continuing Medical Education Requirements and when such requirements become effective. This was given.

### Adjournment

The President, by general consent, declared the House adjourned *sine die* at 10:45 AM.

WILLIAM A. PILLSBURY, MD, Secretary




"Am I late?"

# THE COLD RUSH OF '72

## Meet it with Cerose® for coughs of colds

*empt Narcotic*

**EROSE®** for relief of coughs due to lds, whenever an antitussive formu- ion having sedative, decongestant, tihistaminic, and expectorant actions required

ch 5-cc. teaspoonful contains: codeine sphate, 10.0 mg. (*Warning:* May be habit ming); phenindamine tartrate, 10.0 mg.; enylephrine hydrochloride, 5.0 mg.; fluid- ract of ipecac, 0.17 minim; glycerin, 40 nims; potassium guaiacolsulfonate, 86 .; sodium citrate, 3 grains; citric acid, 1 in; in a palatable, grape-flavored base, ohol 2½%

*Non-narcotic*

**CEROSE-DM®** for relief of coughs due to colds. It diminishes the cough reflex, promotes expectoration, and provides effective vasoconstriction and bronchodilatation. Contains non-narcotic dextromethorphan

Each 5-cc. teaspoonful contains: dextromethorphan hydrobromide, 10.0 mg.; phenindamine tartrate, 5.0 mg.; phenylephrine hydrochloride, 5.0 mg.; fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, mixed fruit-flavored base, alcohol 2½%

*Exempt Narcotic*

**CETRO-CIROSE®** for relief of simple coughs where a plain sedative-expectorant is required. An excellent vehicle for many other commonly employed adjunctive cough medications, as preferred by the physician

Each 5-cc. teaspoonful contains: codeine phosphate, 5.0 mg. (*Warning:* May be habit forming); fluidextract of ipecac, 0.17 minim; glycerin, 40 minims; potassium guaiacolsulfonate, 86 mg.; sodium citrate, 3 grains; citric acid, 1 grain; in a palatable, cherry-flavored base, alcohol 1½%

**IVES LABORATORIES INC.**
New York, N.Y. 10017

DEDICATED TO IMPROVING THE QUALITY OF LIFE, THROUGH MEDICINE

175th ANNUAL MEETING

# MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

APRIL 25, 26, 27, 1973

BALTIMORE CIVIC CENTER

## SCIENTIFIC EXHIBITS

Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the **Baltimore Civic Center** on

**APRIL 25, 26, 27, 1973.**

Ample space is available, however, it is suggested that applications be submitted as soon as possible.

### APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: .....

.....

2. Please attach a 50-100 word description of the exhibit: .....

3. Give amount of space required, depth, width, and height: .....

If exhibit has side panels, are depth and width included above? .....

If not, what additional space is required? .....

4. Electrical or other requirements: .....

.....

5. Has exhibit been shown at other medical meetings? .....

.....

6. Name and title of exhibitor: .....

.....

7. Name of institution cooperating in the exhibit: .....

.....

8. Address of exhibitor: .....

.....

### RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 500 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.



# Nose clear all knight

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

**Dimetapp® Extentabs®**

Dimetane® (brompheniramine maleate), 12 mg., phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

A·H·ROBINS

A. H. Robins Company
Richmond, Va. 23220


for today's pain...
memory of yesterday's pain...
apprehension over tomorrow's pain–

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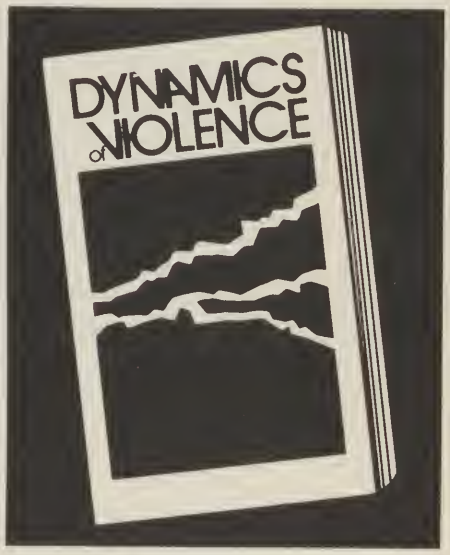
**Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓒ III Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

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**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

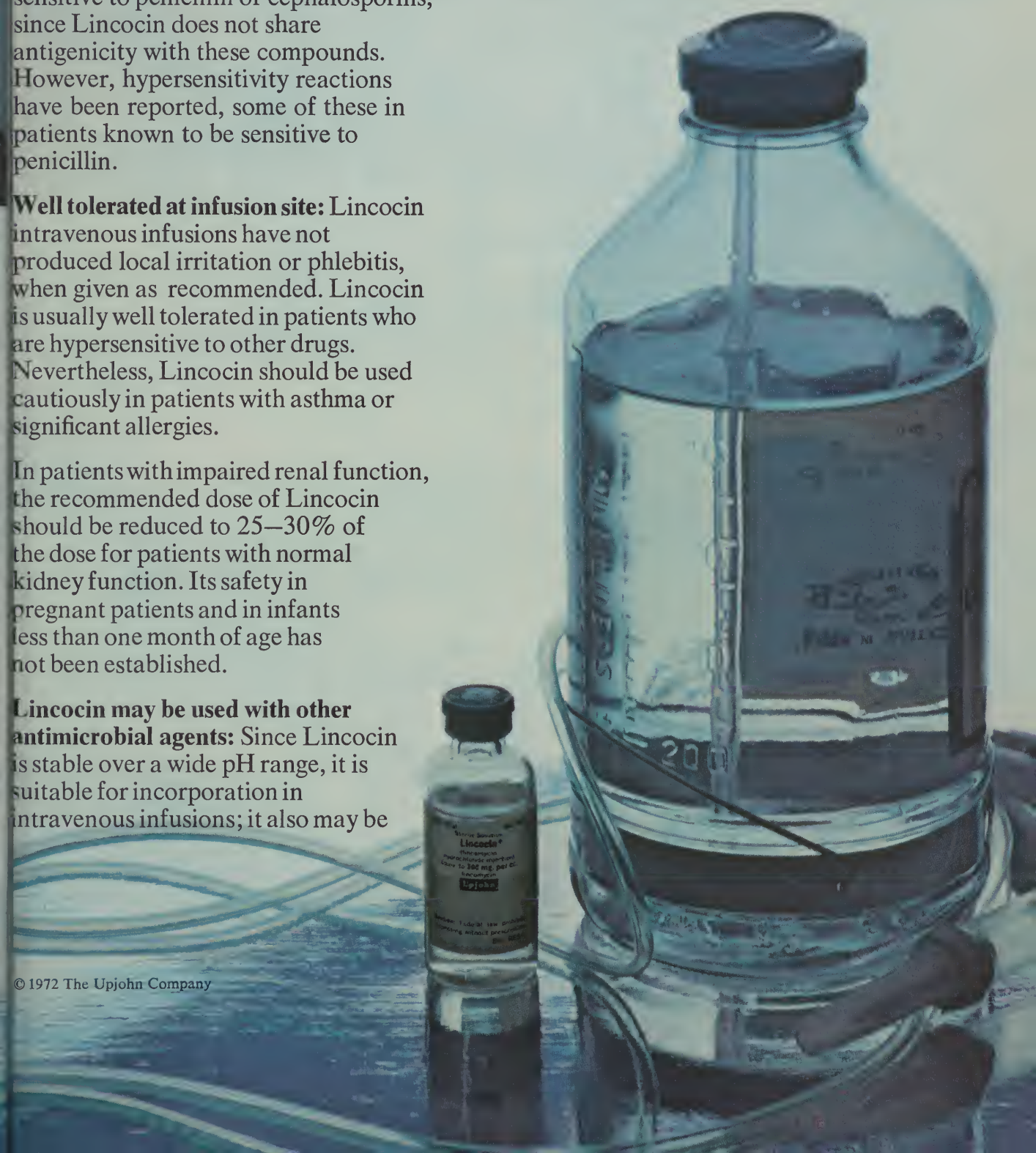
**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

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| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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# Nineteenth Century Medicine in America

*(Continued from October)*

**Medical America in the nineteenth century: readings from the literature** was edited by Gert H. Brieger, who received his MD from UCLA, his MPH from Harvard, and a PhD from Johns Hopkins University. He is now associate professor of history of medicine, Duke University, Durham, NC. From 1966-1968 he was assistant professor, School of Medicine, Johns Hopkins University. He was affiliated with the Institute of the History of Medicine, JHU, while a candidate for Doctor of Philosophy and is eminently qualified to produce this companion volume to the Rothstein publication which followed it by a few months.

Dr. Brieger states in his preface that his purpose is to fill the need for a source book on the development of the medical profession, especially in public health, in the nineteenth century. It is not a classical collection, but selections of works that highlight problems and attitudes encountered in that time in order to understand what our forebear thought.

A succeeding volume showing development of scientific medicine from 1880 to World War II, the period of emerging eminence for the United States in world medicine, will appear later.

Several of the titles in this book sound very familiar to us today, such as Stephen Smith's **New York the unclean.** Brieger has classed his selections into general categories which include medical education, medical literature, the medical profession, medical practice, surgery, psychiatry, hospitals, and hygiene. It ends with a chapter called **Announcement of Johns Hopkins Medical School** which includes the officers, trustees, and faculty listings with opening date, terms of admission, and a short history of the school. It closes with the address at the first graduation on June 13, 1893 by Professor William H. Welch, MD and the terms of Miss Mary Elizabeth Garrett's gift which required that the school offer all the advantages of the medical school to women on the same terms as men.

This book, while entirely different in composition and context, provides interesting reading and complements the Rothstein title in a totally different treatment. Both titles are published by the Johns Hopkins Press.

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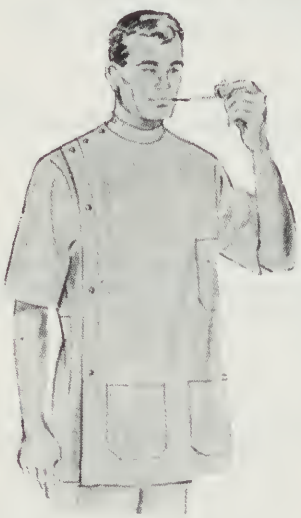
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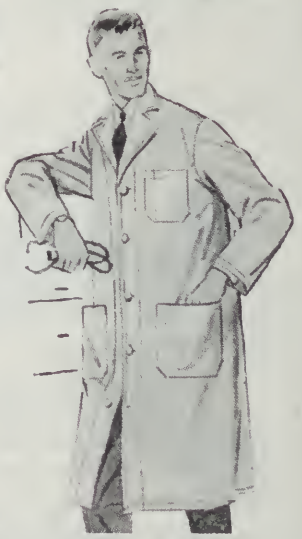
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# LOCAL HEALTH SERVICES

J. HOWARD BEARD, MD, MPH
Deputy State and County Health Officer, Anne Arundel County
President, Maryland Conference of Local Health Officers
and
CHARLES M. YOST
Health Educator
Anne Arundel County Health Department

Maryland historically has been a staunch proponent of strong and effective local health services; 175 years ago, Baltimore City introduced health ordinances to protect and promote the health of its citizens. Ultimately, the state earned the distinction of being the first in the nation to achieve the goal of full-time health services functioning in every county. For nearly half a century, this system has withstood critical scrutiny and emerged as the most optimal method yet devised for the delivery of public health services to the people of Maryland.

The local health department, administered by a full-time physician qualified in public health practices, is the basic or "grass roots" unit for the delivery of services. These physicians — county health officers — are designated, too, as deputy state health officers because of the close cooperation of the local health departments with the Maryland State Department of Health and Mental Hygiene. The local health department is staffed by full-time professional, administrative, technical, para-professional, and secretarial personnel; each person is fully qualified by training and experience, for their respective duties, as required under the merit system of the state or county.

A definite ratio of personnel to population is utilized by the Case Formula in the determination of the size of staff, in each category, for every county department; eg, one public health nurse per 3,700 persons or one sanitarian per 11,000 persons. On this basis, Baltimore City, with a projected population of 897,000, is entitled to the largest number of staff, while Kent County, with a projected population of 15,000, would theoretically have the least number of staff.

Perhaps one of the most popular misconceptions of the function of a local health department is that its responsibility lies solely in the enforcement of health laws, codes, and regulations promulgated by the state and/or county. Although a significant number of the responsibilities of a local department are clearly the mandate of the legislature, others that must be assumed extend far beyond this legal authority. The Arden House Task Force, a special committee of the American Public Health Association, has aligned the latter into three distinct categories: 1) promotion of personal and community health, 2) maintenance of a healthful environment, and 3) an aggressive attack on disease and disability. The local health department must coordinate its activities with the local medical society, dental society, allied professions, hospitals, voluntary health agencies, allied official agencies, and the general public if the endeavor to fulfill these responsibilities is to be successful.

Initially, local public health services included the compilation of vital statistics, sanitation, maternal and child helath services, communi-

cable disease control, laboratory services, and health education. Crippled children's services, mental health services, school health services, venereal disease control, tuberculosis control, and the Maryland Medical Care programs were added later as the need for these specific services developed.

Currently, local health departments are continuing to strive to meet the challenge of providing expanding services such as the health aspects of the environment; also new programs involving home health services, geriatric services, family planning, alcohol and other drug abuse. The range and scope of services necessarily varies from county to county depending upon the individual needs of the respective communities and their budgetary ability to provide them.

Although each local department continually engages in the process of re-evaluation of its services and community needs (in conjunction with advances in science, technology, and the desires of the people) it is obligated to operate within the limits of the finances allotted in the budget. Major funding is primarily provided from federal, state, and local governments; however, other sources are available, on occasion, for specific programs. The Case Formula, developed by the Maryland State Legislature in 1956, determines the basic annual allotment of federal-state and local funds for each department on a percentage ratio which varies from county to county. Recently, the state has made funds available, too, on a 100%-grant basis, for special services; eg, innovative mental health, alcoholism or drug abuse programs.

The local department's responsibility for the provision of an adequate public health program does not end, however, with the mere establishment of facilities and services, for unless they are utilized by the citizens they are inconsequential. Therefore, the department must not only make the services and facilities "available, accessible and acceptable"; it must engage, too, in a continuous process of education whereby the people are encouraged and motivated to utilize the resources that are provided.

●

Hunters who use corrective glasses are urged to make certain they are of the safety variety. Impact-resistant lenses will more adequately protect the eyes from stray pellets, ejecting shells, twigs, and other dangers, without reducing visibility, advises the National Society for the Prevention of Blindness.

## Regional Medical Programs Fact Book Available

In August 1971, as a Special Report to the National Advisory Council of the Regional Medical Programs Service, DHEW, published a *Fact Book on Regional Medical Programs.*

The 67-page publication might be of interest to directors of medical education, as its five sections include discussions of

1) The purpose and history of Regional Medical Programs (RMPs),
2) The characteristics of RMPs,
3) How RMPs are organized,
4) What RMPs do—their program activities, and
5) Progress RMPs have made.

Sections three through five should be especially informative for those in the field of continuing medical education. Section III highlights the organizational structure of RMPs, including the composition and function of Regional Advisory Groups, task forces, committees and staffs. The "Program Activities" Section (IV) outlines the kinds of activities carried out by the Programs, including how and what they plan, implement and evaluate. Section IV also describes what RMPs do to implement their programs in these five major functional areas:

1) Continuing education,
2) Manpower productivity and distribution,
3) Organization and delivery for patient service,
4) Research and development, and
5) Program coordination and administration.

Finally, Section V describes RMP progress toward manpower utilization and resources through training and demonstration activities. It also describes the extent of hospital participation and geographic scope as an index of the regionalization of health services.

For individual copies of the publication, write to Office of Communication and Public Information, Regional Medical Programs Service, Health Services and Mental Health Administration, 5600 Fishers Lane, Rockville Md 20852.

●

The National Society for the Prevention of Blindness warns that wearing sunglasses can cause loss of visibility and increase the difficulty of distinguishing between contrasting colors. Sunglasses should be removed before driving home at dusk to allow the driver to clearly observe important road signs necessary for safe driving.

# An Ounce of Prevention

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MEDIC-ALERT bracelet, above, carries life-saving data about its wearer. Below, AMA-designed symbol identifies emergency medical information the world over.



Linda, a 14-year-old physician's daughter, walked quickly into the Medical Center, a handkerchief wrapped tightly about her bleeding finger. As a doctor's daughter, Linda was conscious of the dangers of infection. In her father's absence, she had gone to her physician-uncle to have the cut treated.

After cleaning the wound the doctor-uncle scratched a droplet of tetanus antitoxin into the skin to check for a reaction before giving the full injection. Within seconds Linda collapsed, gasping for breath, struck by the often fatal allergic reaction—anaphylaxis.

Emergency measures were quickly administered. After three days in intensive care, Linda finally was out of danger. But was she? What can be done to protect this child against future injection of tetanus antitoxin — an injection almost guaranteed to be more hazardous — possibly fatal.

According to the American Medical Association one in every five persons lives in fear that his hidden medical problems will not be discovered when he is in shock, unconscious or for some reason unable to communicate.

A number of solutions have been tried, such as notes taped to the body, wallet-sized warning cards and tatooes. Then in 1953, Marion C. Collins, MD, came up with the idea of a chain bracelet or necklace with an eye-catching disc.

On one side in red are the words "Medic Alert" and the caduceus symbol of the medical profession. On the other side is engraved the warning, the diagnosis which can be life-saving for the individual who is unable to communicate.

Emergency symbols are now available and in widespread use throughout the world. And they help guard against possible fatalities from some 200 hidden or obscure diseases and conditions.

For example, epilepsy affects the lives of about 1.5 million Americans. An epileptic reports, "I blacked out on my way to work. Since my seizures resemble drunkenness, police would have arrested me on the spot if it had not been for my Medic-Alert disc. Prior to my becoming a member of Medic Alert, I had been jailed many times for drunkenness."

There are about two million known diabetics who take insulin. In addition to rigid health routines these persons would possibly benefit from the safety of wearing a Medic-Alert bracelet.

People who wear contact lenses can damage the cornea of the eyes if the lenses are left in too long.

Many millions of cardiac, arthritic and rheumatic patients are potentially vulnerable to common anesthetics, stimulants and sedatives.

All these classes of people can have the protection and peace of mind that Medic Alert affords for a $7 lifetime membership fee. Information is available from Medic-Alert Foundation International, Turlock, Calif 95380.

The other symbol most

widely used and recognized is the American Medical Association's universal emergency medical identification symbol which was released nine years ago. This symbol combines the star of life with the sign of Aesculapius.

Vital medical information may be engraved on this signal device itself, or, when that isn't possible, it may be carried separately on a card in the billfold. The symbol is internationally recognized, having been adopted by the World Medical Association in Helsinki during the 1964 Assembly.

Most physicians, nurses, policemen, firemen, and emergency rescue personnel know how the symbol works: when worn it identifies the wearer as someone who is carrying vital information about himself.

Many of the Medic-Alert bracelets now in circulation display both AMA and the Medic-Alert symbols. There are also a number of emergency ID cards on the market, some simple, some elaborate.

One recent addition to the field is a plastic-encased card containing a small "window" which reveals the bearer's complete medical history on microfilm. The most popular ID card is the AMA's simple wallet-sized ID card of which more than five million have been distributed.

Information about the American Medical Association's Emergency Symbol may be obtained from AMA Department of Health Education, Donald H. Dukelow, MD, Assistant Director, 535 N Dearborn Blvd, Chicago, Ill 60610.

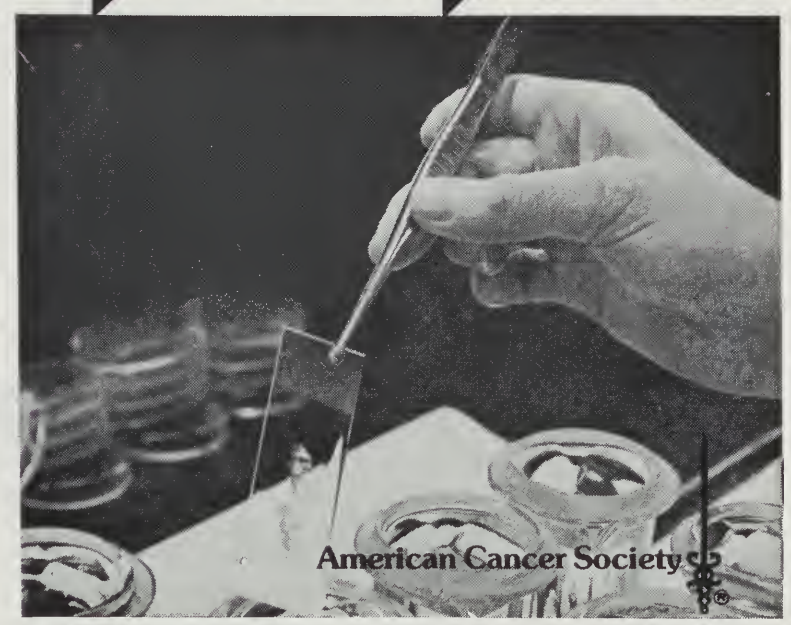

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We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action that will involve the doctor, the patient, the American Cancer Society—a partnership for life.

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For additional information contact

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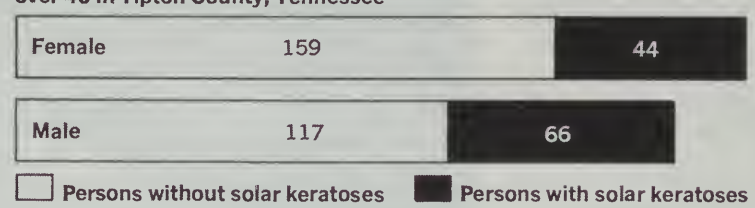
# What it means to live and work in Tipton County, Tennessee

## Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee**




*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



## Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

## Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

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**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

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### For the tense cardiac patient who must be kept calm

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose ® packages of 1000.

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VOLUME 21 DECEMBER 1972 NUMBER 12


**ARTICLES:**


**An Interim Program for Emergency Psychiatric Evaluation in Baltimore City—**
Alan H Peck, MD ..... 43

**Carcinoma in Situ of Cervix Revisited—**
Gerardo Araza, MD; Umberto Villasanta, MD ..... 48

**Skin Manifestations of Internal Malignant Tumors—**
Helen Ollendorff Curth, MD ..... 52

**Primary Care Nurse Practitioner Program—**
Susan Dilts ..... 57

**The Physician's Legal Duty to Refer a Patient to a Specialist—**
James G Zimmerly, MD; James W Gocke, JD ..... 63

**Industrial Medicine and the Law—**
Charles J Frankel, MD ..... 65


**DEPARTMENTS:**


**Maryland Medical Political Action Committee** ..... 12

**Woman's Auxiliary—Eating Habits** ..... 13

**Your Medical Faculty at Work**—John Sargeant ..... 16

**Heart Page—The Syndrome of Midsystolic Extra Sound and Late Systolic Murmur**—William E Shell, MD ..... 18

**Executive Director's Newsletter** ..... 21

**Baltimore City Health Department—Advisory on Animal Bites** ..... 36

**Library—Eduard Jaeger Ritter Von Jaxthal; New Accessions** ..... 74

**TB-RD—Final Report on the Tuberculin Testing Program—**
Connie Sawyer, RN ..... 82

**Emergency Medicine—Present and Future Status of Telemetry in Emergency Medical Services**—Eugene L Nagel, MD ..... 90



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**MISCELLANY:**


Doctors Take Note 5
Continuing Med Educ 8
Hospital Salute 9
Utilization Review Task Force 14
Art & Hobby Exhibit 17
Health Evaluation Tests 24
New Council Members 26
Doctors in the News 27
Annual Meeting 30, 88, 89
Medical Miscellany 31, 51, 56
Seminannual Meeting 38
Book Reviews 47
Open Forum 69
PMA Editorial 69
Component Societies 73
Amer Assoc Med Assts 84
Info for Authors 85
Classified Advertising 95
Advertising Index 96

# Should old depressives be forgot?

e geriatric depressive.
Unable to concentrate he tends
ake little interest in the affairs
und him. His reactions are slow
delayed. He speaks very little.
en he does, it's mostly to com-
in of his insomnia, fatigue, or
stipation.

One way of relieving depression in the geriatric patient is with Tofranil.

Please read the prescribing information for details of usage (lower dosages are recommended for elderly patients and adolescents), precautions, warnings, contraindications, adverse experiences, and dosage recommendations. It is summarized below.

## Tofranil® Geigy
imipramine hydrochloride USP



**anil® imipramine hydrochloride USP**

**traindications:** The concomitant use of this agent monoamine oxidase inhibiting (M.A.O.I.) comds is contraindicated. Hyperpyretic crises or re convulsive seizures may occur. Potentiation of rse effects can be serious or even fatal. An interval least 14 days after M.A.O.I. therapy has been ntinued should be allowed before this drug may bstituted. Initial dosage should be low, increases ld be gradual, and the patient's progress should refully observed. The drug is also contraindicated uring the acute recovery period after myocardial rction. (b) in patients with known hypersenity to the drug. Cross-sensitivity to other dibenzine compounds should be kept in mind.

**Warnings:** *Usage in Pregnancy:* Safe use of ramine during pregnancy and lactation has not established; therefore, in administering the drug regnant patients, nursing mothers, or women of ldbearing potential, the potential benefits must be ghed against the possible hazards. Animal reprotion studies have yielded inconclusive results. re have been clinical reports of congenital malhation associated with the use of this drug, but a sal relationship has not been confirmed.

Extreme caution should be used when this drug ven to:

tients with cardiovascular disease because of the ssibility of conduction defects, arrhythmias, yocardial infarction, strokes and tachycardia;
tients with increased intraocular pressure, history urinary retention, or history of narrow-angle aucoma because of the drug's anticholinergic roperties;
perthyroid patients or those on thyroid medicaon because of the possibility of cardiovascular xicity;
tients with a history of seizure disorder because is drug has been shown to lower the seizure reshold;
atients receiving guanethidine or similar agents nce imipramine may block the pharmacologic fects of these drugs.

*Usage in Children:* Pending evaluation of results n clinical trials in children, the drug is not recomded for use in patients under twelve years of age.

Since the drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

**Precautions:** Because of the possibility of suicide in seriously depressed patients, careful supervision during the early phase of treatment is necessary and hospitalization may be required. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential.

**Adverse Reactions:** *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

*Psychiatric:* Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

*Neurological:* Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

*Anticholinergic:* Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

*Allergic:* Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with desipramine.

*Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

*Gastrointestinal:* Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

*Endocrine:* Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

*Other:* Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

*Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

**How Supplied:** Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration. (B)98-146-850-H (7/71)

**For complete details, including dosage, please refer to the full prescribing information.**

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TO 8575



# When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

**1.2 to 8 grams/day IV dosage range:** Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

**Effective gram-positive antibiotic:** Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

**Well tolerated at infusion site:** Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

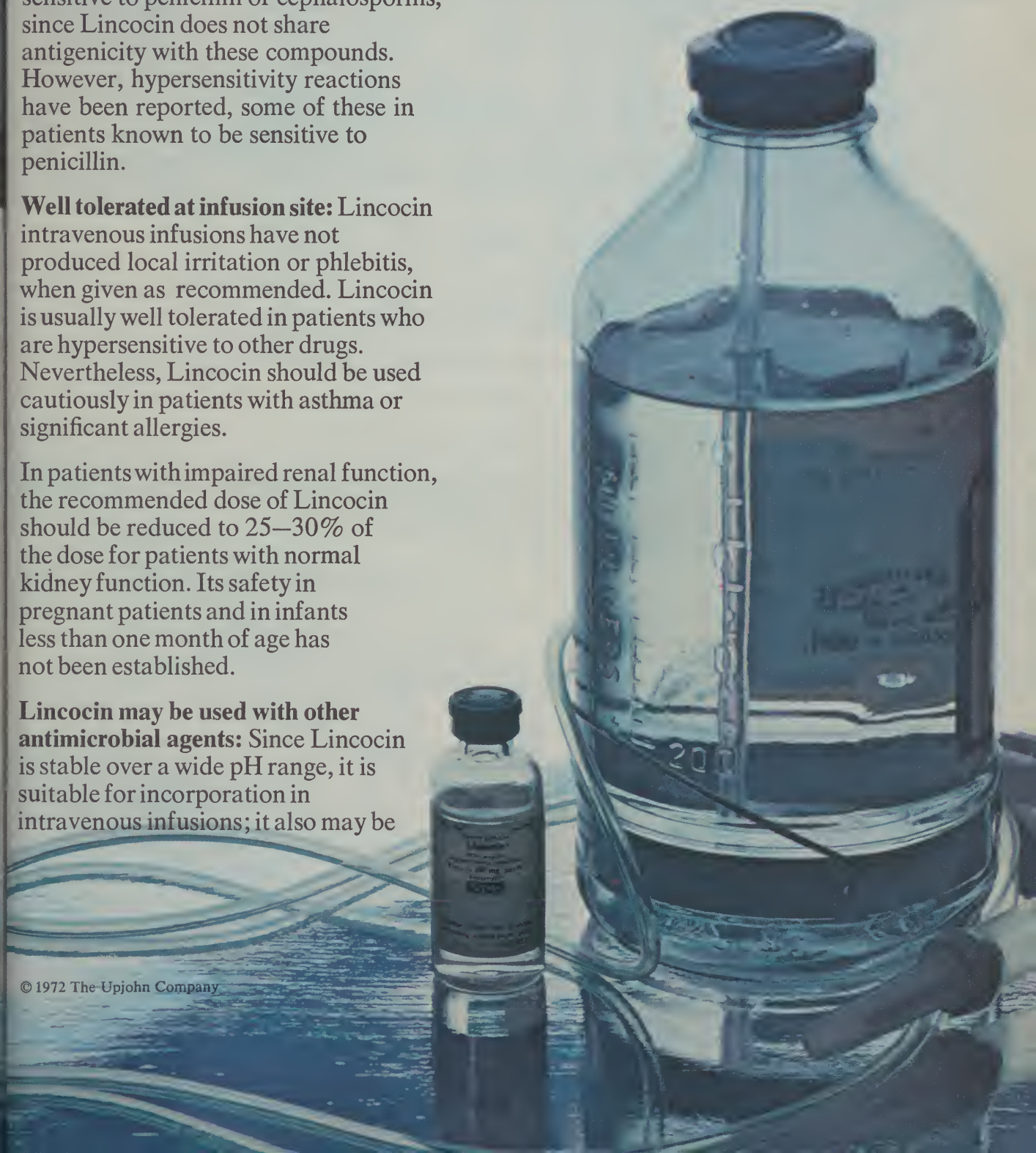
**Lincocin may be used with other antimicrobial agents:** Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

# Lincocin®

Sterile Solution (300 mg per ml)

## (lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



© 1972 The Upjohn Company



Sterile Solution (300 mg. per ml.)

# Lincocin®

# (lincomycin hydrochloride, Upjohn)

## Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

| Each preparation contains: | Lincomycin hydrochloride monohydrate equivalent to lincomycin base |
|---|---|
| 250 mg Pediatric Capsule | 250 mg |
| 500 mg Capsule | 500 mg |
| *Sterile Solution per 1 ml | 300 mg |
| Syrup per 5 ml | 250 mg |

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 mg* Capsules—bottles of 24 and 100. *Sterile Solution, 300 mg per ml*—2 and 10 ml vials and 2 ml syringe. *Syrup, 250 mg per 5 ml*—60 ml and pint bottles.

*For additional product information, consult the package insert or see your Upjohn representative.*

MED B-6-S (KZL-7) JA71-1631

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Kalamazoo, Michigan 49001

**Upjohn**

# Doctors take note...

## MARYLAND AREA

Feb 25-27 — **Topics in Neurology,** Dept of Neurology, Johns Hopkins Hosp. Crs designed to relate new Info on basic mechanisms of disease to diagnosis & mgt of clinlcal problems. Limited to 125. Contact: John M Freeman, CMSC 801, Johns Hopkins Hosp, 601 N Broadway, Baltimore Md 21205.

Mar 1-April 5 — **Univ of Maryland Sch of Medicine,** Baltimore. 2nd series of 6 consecutive Thursdays of selected topics in gen & family practice. Prepare for board exams or recertification. 15 hrs cr AAFP. Contact: Univ of Md Sch of Med, Comm on Continuing Med Educ, Baltimore Md 21201, 528-7346.

Apr 25-27 — **Med-Chi 175th Anl Mtg,** Civic Center, Baltimore.

## AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104).

Jan 8-10 — **Three Days of Liver Disease,** Emory Univ School of Med, Royal Coach Motel, Atlanta. 21 hrs cr.

Feb 8-10 — **Recent Advances in Immunoprophylaxis & Chemotherapy of Infectious Diseases,** Univ of Arizona Col of Medicine, Tucson.

Feb 26-Mar 2 — **Clinical Gastroenterology,** Univ of Michigan Med Cen, Ann Arbor.

Mar 5-8 — **Problems of International Health,** Naval Hosp, San Diego, LeBaron Hotel, San Diego.

Mar 5-8 — **Modern Neurological Diagnosis & Therapy,** Univ of Miami, Edin Roc Hotel, Miami Beach.

Mar 12-16 — **Infectious Diseases,** Univ of Maryland Sch of Med, Baltimore.

Mar 14-16 — **Clinical Pharmacology—Rational Basis of Therapeutics,** Univ of Calif Sch of Med, San Francisco.

Mar 19-23 — **Internal Medicine: What's New?** Univ of Alabama Med Cen, Birmingham.

## MISCELLANEOUS

Jan 5-22 — **14th Postgrad Med Seminar Cruise,** Dept of Postgrad Med, Albany NY. Cruise from NY on GRIPSHOLM to Carribean ports. Contact: F M Woolsey Jr, MD, Dept of Postgrad Med, Albany Med Col, Albany NY 12208.

Feb 25-Mar 3 — **Amer Society of Contemporary Med & Surgery,** anl mtg, Fountainbleu Hotel, Miami Beach. Continuing med educ crs. Contact: Va Kendall, Suite 1629, 30 N Michigan Ave, Chicago Ill 60602.

Feb 25-Mar 1 — **Pediatric Cardiopulmonary Care,** Amer Col of Chest Physicians & Pedlatric Pulmonary Dept, Univ of Colorado Med Cen, Aspen Col. Contact: AACP, 112 E Chestnut St, Chicago Ill 60611.

Feb 26-Mar 2 — **Mgt of Acute Cardiorespiratory Failure,** Amer Col of Chest Physicians & Univ of Miami Sch of Med, Miami. Contact: AACP, 112 E Chestnut St, Chicago Ill 60611.

Mar 5-10 — **Crs in Laryngology & Bronhoesophagology,** Chicago. Sponsor: Abraham Lincoln Sch of Med & Univ of Illinois Hosp Eye & Ear Infirmary. Crs limited to 15. Contact: Dept of Otolaryngology, Eye & Ear Infirmary, 1855 W Taylor St, Chicago Ill 60612.

Mar 15-16 — **22nd Anl Postgrad Crs in Pediatrics,** Galveston Tex. 12 hrs AAGP. $75 regis fee. Contact: Lillian H Lockhart MD, Dept of Pediatrics, Univ of Texas Med Branch, Galveston Tex 77550.

Mar 26-29 — **Crs in Neurotology,** Chicago. Sponsor: Abraham Lincoln Sch of Med & Univ of Illinois Hosp Eye & Ear Infirmary. Limited to 12. Contact: Dept of Otolryngology, 1855 W Taylor St, Chicago Ill 60612.



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
*and* the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for solc therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

# Valium®
# (diazepam)

To help you manage excessive psychic tension

# A NOTE ON CONTINUING MEDICAL EDUCATION

Effective July 1, 1972, the Board of Medical Examiners was given authority to require continuing medical education in order for a physician's license to be reregistered triennially. Regulations to implement the requirements of this statute have been developed and are currently under consideration by the Department of Health and Mental Hygiene.

There has been some confusion in the minds of individual physicians with respect to what they personally are required to do. The board is requiring that 150 hours be earned over the three-year period. The specifics of these hours and the categories are listed at the conclusion of this article.

However, each physician must first be notified that he will be expected to complete the 150 hours. The earliest this can be done is during the 1973 calendar year when those physicians whose surname begins with L-S will be sent their reregistration forms. When this group of physicians is reregistered in 1976, they will be expected to certify their compliance with the educational requirement. Those physicians whose surname begins with the letters T-Z will be so notified in 1974 and will be required to be in compliance when they reregister in 1977. Those physicians whose surnames begin with A-K will be notified in 1975 and will be required to be in compliance when they reregister in 1978.

For additional information, please contact the Faculty office or the Board of Medical Examiners.

## Proposed Regulations for Continuing Medical Education

1) The Maryland State Board of Medical Examiners requires 150 hours of continuing education every three years. These may be distributed over the period or they may all be obtained in one year.

2) The Board will accept the Physicians Recognition Award of the American Medical Association and the Certificate of Continuing Education of the American Academy of Family Physicians and will also consider approval of programs of other organizations as they are developed.

3) In case licensees fail to meet the requirements because of illness or other extenuating circumstances each case will be considered by the Board on an individual basis and, when circumstances justify it, may grant an extension of time.

4) Types of credits allowed:

I. Required education — 30 hours

II. Elective category

At least 30 of the 150 hours must be in required education.

### Definitions

A credit hour is on the basis of one clock hour of participation in a continuing education activity.

### Required Education

**Category 1:** Internship, residency or fellowship; 50 credit hours per year during service in AMA-approved program for training.

**Category 2:** Education for an advanced degree in a medical field or medically related field. Fifty credit hours are allowed for each full academic year of study.

**Category 3:** Research in lieu of training. Credit is given only for full-time research. Fifty hours for each full year of research.

**Category 4:** Continuing education or postgraduate courses. A course is considered to be a series of educational procedures that are planned, coordinated, and organized to meet specific educational objectives for a defined group of physicians. Courses offered by any organization or institution listed as a course sponsor or cosponsor in "Continuing Education Courses for Physicians," *Journal of the American Medical Association,* are creditable. (Physicians Recognition Award) The average practicing physician will fulfill most of his required education in this category.

**Category 5:** Teaching: One credit hour is allowed for each clock hour of teaching of medical students or physicians in an approved medical school or approved internship or residency program, not to exceed 90 hours.

**Category 6:** Papers or Publications. Ten hours may be claimed for each medical scientific paper or publication. A paper must be presented to a recognized international, national, regional, or state medical society or other medical organization. A publication must appear in a regular recognized medical or medically related scientific journal. Scientific material used in the paper or publication may be credited only once.

### Elective Education

Attendance at hospital staff meetings, city or county society meetings, regional, national, or international scientific meetings or journal clubs. One hour credit for each hour of attendance.

### Procedures

1) The Secretary will provide a form for the listing and documentation of claimed credits for continuing medical education with the application for reregistration.

2) When the statements are returned to the Secretary of the Board, he will check them and the credits allowed the licensee will be placed on record.

## Med-Chi Salutes

# THE JOHNS HOPKINS HOSPITAL

The Johns Hopkins Hospital is part of the Hopkins Medical Institutions which form a medical center that includes patient care, teaching, and research.

The Hospital services include 1,105 inpatient beds, serving more than 32,400 patients annually. There are 125 outpatient clinics which serve more than 538,850 patients annually. The Hospital operates on an annual budget of over $57 million.

The Hospital staff consists of more than 4,300 employees, 1,081 staff physicians, 335 interns and residents, and 550 registered nurses.

Closely affiliated with the Hospital are the Johns Hopkins Medical School and the School of Hygiene and Public Health.

The Hospital has been instrumental in shaping the East Baltimore Medical Plan and the Columbia Medical Plan, two community prepaid health care plans.

Dr Steven Muller was elected Johns Hopkins Hospital president Oct 1 succeeding Russell A Nelson, MD, who became president emeritus and trustee. Robert M Heyssel, MD, is executive vice president and director of the Hospital.

## Johns Hopkins Elects Officers

The Johns Hopkins Hospital Board of Trustees has elected Johns Hopkins University President Steven Muller as president of the Hospital.

William E McGuirk Jr, chairman of the Hospital Board, said retiring Hospital President Russell A Nelson has been elected president emeritus and trustee.

In addition, and on the recommendation of the new president, the Board appointed Robert M Heyssel, MD, 44, as executive vice president and director of the Hospital.

Mr McGuirk said that though the Hospital and University have been intimately associated since their founding, "the rapid and extensive development of joint School of Medicine and Hospital programs in recent years makes it highly appropriate that the presidencies of the institutions now be combined."



Dr Muller



Dr Heyssel

The trustees are confident, he said, that "combining the presidencies under Dr Muller will make the Hospital even stronger, and that it will simplify the administrative coordination of the Johns Hopkins Medical Institutions, enabling swift response to developing needs."

The new president came to Johns Hopkins in 1971 as provost of the University, and became University president seven months ago. Dr Muller, who is 44, had been vice president for public affairs at Cornell University for five years before coming to Hopkins.

He has an undergraduate degree from UCLA, a BLitt degree from Oxford University in England, where he studied as a Rhodes Scholar, and a PhD in political science from Cornell.

Dr Nelson has agreed to continue at Johns Hopkins in a part-time capacity to provide advice, counsel and assistance with Hopkins' development program, Mr McGuirk said. Dr Nelson announced in June that he wished to be relieved of his executive duties in order to devote the remainder of his career to health services planning and development.

Dr Heyssel, who has directed Johns Hopkins' Office of Health Care Programs since 1968, will become the Hospital's chief operational officer, Dr Muller said.

Since joining the Hopkins staff, Dr Heyssel has directed the development of Johns Hopkins' comprehensive care program in Columbia, Md and, with the East Baltimore Community Corporation, has developed a similar program in East Baltimore.

In addition, he is professor of medicine and associate dean of the School of Medicine, director of the Hospital outpatient department, and president of the Columbia Hospital and Clinics Foundation.

Dr Heyssel, who was on the faculty of Vanderbilt University for nine years before coming to Hopkins in 1968, directed the radioisotope center and the division of nuclear medicine and biophysics of Vanderbilt's department of medicine.

Earlier, he had been senior assistant surgeon with the US Public Health Service, assigned to the Atomic Bomb Casualty Commission in Hiroshima and Nagasaki, Japan.

Dr Heyssel's research activity has covered a variety of areas, most recently health services development and delivery. In Japan, he studied the effects of ionizing radiation on humans, and provided the first description of the dose-response relationship of radiation to human leukemia in a nonselected large population.

At Vanderbilt, his work included studies of the distribution and life span of blood platelets; iron metabolism; and Vitamin B-12. He made the first large-scale study of the absorption of Vitamin B-12 from natural foods, and the first reasonably based estimates of the minimal daily dietary requirements for B-12.

Dr Heyssel received his BS degree from the University of Missouri in 1951, and his medical degree from St Louis University in 1953. His advanced training was taken at St Louis University, Veterans Administration Hospital, Barnes Hospital, and Washington University School of Medicine, all in St Louis.

He is a fellow of both the American College of Physicians and the International Society of Hematology, and holds membership in numerous other professional and learned societies.

## Johns Hopkins Medical Institutions Plan for the Future

A paper outlining tentative program and new facility goals for the future development of the Johns Hopkins Medical Institutions has been under study by Hopkins faculty and staff for the past year.

Considered an internal document for planning purposes, the paper focuses on suggestions and recommendations for the major areas of education, research, and patient service and facilities.

The proposals represent a synthesis of plans evolved since 1964 by various planning bodies, faculty committees and leadership groups. Though it concentrates on the Hospital and School of Medicine, the paper notes that the School of Hygiene and Public Health has taken steps to define its program and facility needs, and has an important stake in the development of the Medical Institutions.

The paper makes clear that the institutions' future development hinges on achieving financial stability, and both the Hospital and School of Medicine have resolved to operate without deficits. The paper recommends that the institutions begin vigorous activity to increase revenue from both public and private sources.

Certain priorities already exist for construction of physical facilities, the paper says.

These include immediate construction of radiology facilities with about twice the present capability; construction of an obstetrical facility; construction of new private accommodations; replacement or renovation of the psychiatric unit and construction of a long-term psychiatric unit; the addition of minimal care and extended care facilities; and the addition of a rehabilitation medicine demonstration unit.

It is generally agreed now, the paper says, that the Hospital's current size be maintained, with perhaps even a modest increase in the number of beds. This agreement is the result of deliberations which followed the distribution of an earlier discussion paper, "Hospital Services in the 1970s," which suggested last year that there be a reduction in beds.

The paper also recommends the establishment of a centralized outpatient facility that would permit a merger of certain Hopkins' 145 clinics, and a strengthening of specialty clinics.

The paper notes that the strength of Johns Hopkins will continue to depend on joint participation of the part-time, full-time and resident staffs, and recommends the development of effective means of maintaining a proper balance of these groups to produce the most effective operation of each.

Members of the part-time medical staff and faculty, the paper suggests, should receive adequate compensation for services they render and be given adequate opportunity for their clinical practice.

A major educational recommendation is that Hopkins implement already approved MD-PhD programs in the classical hard sciences and social sciences, without increasing the number of med-

ical students in each class.

Class size recently was increased from 95 to 115, and the paper suggests that judgment about eventual class size be reserved until the effects of the new medical scientist-PhD programs and the recent increase in class size have been observed.

The document suggests that Hopkins' program for interns and residents be recognized as primarily an educational experience. It recommends that the medical care workload, beyond that which has educational content for house staff, be met by employment of junior faculty and greater involvement of part-time clinical faculty on a contractual basis.

Though the Hospital's School of Nursing will close, the Johns Hopkins Medical Institutions will initiate baccalaureate education for nurses along with the training of many kinds of allied health professionals in 1973.

The paper points out that the number of faculty in the basic science, or preclinical, departments of the School has remained relatively constant during a period when the clinical faculty and student body have grown.

It recommends that the central core faculty of the preclinical departments be increased to provide "stable, long-range, and diversified development of basic research programs and to keep pace with the School's growth."

The paper describes the importance of both basic and clinical research in the clinical departments, and recommends that the institutions reaffirm the principles that full-time members of these departments be chosen on the basis of excellence and interest in teaching, research and clinical practice, and that postdoctoral fellows be trained in the image of researcher-teacher-clinician.

The research activities of both preclinical and clinical departments will benefit, the paper suggests, from a total reorganization of the animal care facilities.

Noting Johns Hopkins' involvement in Columbia and the development of another away-from-the-Hospital program in East Baltimore with the East Baltimore Community Corporation, the paper suggests Hopkins should encourage the development of primary care centers by other groups so that the total needs of the community can be met.

The paper notes the many serious problems confronting the East Baltimore area and suggests a willingness by Hopkins to join forces with other community groups to stabilize and upgrade the area as circumstances and the institutions' resources allow.

The paper says that "though the major efforts obviously will be dependent on others and other resources, the Medical Institutions must be involved in the process."

The paper also notes that Hopkins' total plans must be compatible with those of other hospitals and responsive to area needs. The institutions have already taken steps to develop liaison with the Regional Planning Council to "promote effective communication regarding Hopkins' developing plans and local needs."

Johns Hopkins also is working closely with affiliated institutions, especially the Good Samaritan Hospital, the John F Kennedy Institute, and Baltimore City Hospitals, with whom Hopkins' relationship is particularly close and comprehensive.

Many committees and task groups at Hopkins are working to develop detailed recommendations in the areas outlined in the document. In addition, the Stubbins-Allen Partnership has been employed to assist the institutions' planning staff in converting the input from the task groups into a phased redevelopment program.





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Maryland Medical Political Action Committee

RAYMOND L. MARKLEY, MD, Chairman

MRS. FRANCIS C. MAYLE, Editor

# GENERAL PRINCIPLES FOR GOOD HEALTH INSURANCE

Look for these points in any bill:

1) Health care should be financed through the use of voluntary insurance on a risk and underwriting basis.
2) A program should be a voluntary one, encouraging participation through financial incentives rather than through compulsion.
3) Pluralistic means of health care delivery should be afforded.
4) Federal funding should be through general revenues, with any other funds from state and private sources, as opposed to any payroll tax.
5) A separation of medical and institutional components in the financing of any health care plan should be provided so that the separate expenditures are ascertainable.
6) The scope and duration of benefits should be comprehensive in nature, and adequate in their description and provision.
7) The program should be explicit, so as to avoid basic changes in the Congressional intent being made through regulations.
8) Mechanisms for cost and quality must be set up utilizing professional review principles at the local level.
9) State licensure and certification should be maintained.
10) Any corporate arrangements for provisions of medical services should be in conformance with professional ethics.
11) Cost-sharing by the recipient, where financially capable, should be maintained.
12) Government subsidy or assistance should be related to the individual's ability to pay.

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# WHAT ARE YOU EATING NOW?

In its summer issue, *MD's WIFE,* official publication of the Woman's Auxiliary to the American Medical Association, featured an article, "Who Cares About Nutrition," which described the Massachusetts' Auxiliary project to increase public knowledge about proper eating habits. This project came about when Auxiliary President Mrs Stefan Kraus became annoyed that a nation so endowed with agricultural resources should have so many people starving from malnutrition.

She began by setting up workshops in five areas of Massachusetts for a series of eight seminars each. She found immediate support from university educators and nutrition experts in both state and federal government agencies. Dr Jean Mayer, professor of nutrition in the Department of Nutrition at the Harvard School of Public Health, gave her direction, and the Department of Nutrition at the University of Massachusetts furnished her with key personnel for arranging the course. The Massachusetts Medical Society and its Postgraduate Institute, along with the Massachusetts Department of Health, Public Welfare and Education, cooperated with her. Harvard professors and postdoctoral fellows volunteered to lecture at the seminars.

The seminars were designed for women with little nutritional background but who were interested in balanced diets, nutritional meals throughout the life cycle, and planning adequate diets at different cost levels. Many of the women taking the course were doing so to improve the nutrition of their own families but, according to Mrs Kraus, 50% of those completing the course went to work in some area of nutrition.

They have been so successful that the Woman's Auxiliary of the AMA will encourage other state auxiliaries to establish similar programs. By one of those odd coincidences, just as state auxiliaries are becoming aware of nutritional needs, the new president of the Woman's Auxiliary to the AMA, Mrs Robert F Beckley, is a graduate of the University of Pennsylvania in home economics; nutrition is high on her list of priorities.

With the facilities of Maryland medical schools and a state director of health who is a diet authority, it would seem as though Med-Chi and its Auxiliary would be able to give a wonderfully helping hand to fight food fads and quackery which are such a blight on good nutrition.

Unfortunately, some food faddists are too far removed from reality to be influenced by rational nutritional information. A September issue of *Newsweek* contained a frightening account of the effects of the so-called Zen Macrobiotic Diet on children. Parents in the "hip culture" are not adversely affected by this diet since they have a lifetime of good nutrition behind them, but their children show the painful, fragile bones of rickets and the skin eruptions of scurvy. When oranges, fish, eggs, and dairy products are given to these children to supplement the macrobiotic (essentially grains only) diet, their physical condition improves markedly. Pediatricians, though, are particularly concerned about the effect of malnutrition on the developing brain and central nervous system of these pitiful children. The parents blame the children's diseases on "the inferiority of the body rather than the inadequacies of the macrobiotic diet." When the doctors diagnose malnutrition, the parents simply disappear into the hippie underground.

For the average interested citizen, however, a program formed along the lines of that established by the Massachusetts Auxiliary and the Massachusetts Medical Society would be a definite asset to the community.

# UTILIZATION REVIEW TASK FORCE

**J EMMETT QUEEN, MD**
**Director of Medical Affairs**
**Maryland Blue Cross, Inc.**

*Dr Queen is chairman of the Utilization Review Task Force. Other members include Katherine H Borkovich MD, Denwood N Kelly, Louis J Kolodner MD, Christian S Mass MD, Donald C. McAneny, John D Morris MD, Adrian A Samojlowicz, Thomas H Sherlock, John A Stevens, and David L Woodrum.*

*Information and reprint requests to Dr Queen at 700 E. Joppa Rd, Towson, Md 21204.*

For the past year representatives of the Medical and Chirurgical Faculty, the Maryland Hospital Association, Maryland Blue Cross, and Maryland Blue Shield have been meeting regularly to discuss approaches to be taken on a cooperative basis to assure the most effective and economical use of hospital facilities and hospital insurance benefits. To accomplish this end, a Utilization Review Task Force was formed which has held wide-ranging discussions on various aspects of health care and utilization of health insurance benefits. The group has recognized that the subject is a highly complex one, with far-reaching implications for both providers and consumers of health services and benefits.

The responsibility for assuring appropriate use of health care resources lies with physicians, hospitals, and the agencies which finance hospital care. While all of these parties share the overall responsibility, each party also has separate and special responsibilities. The medical profession has the special responsibility for determining the medical necessity and appropriateness of the services prescribed. The efficient and economical delivery of quality hospital services falls under the realm of the hospitals. Insuring agencies are responsible for determining whether such services are covered under the contractual provisions of health care insurance programs. Close cooperation among all three parties is required to achieve an effective utilization of services and financial resources. Attaining these goals also necessitates understanding and cooperation of the patient.

Competent medical judgment must prevail in questions regarding the medical appropriateness of health services and consideration must be given for individual variations. The peer review process is an essential safeguard in assuring the proper application of competent medical judgment.

To accomplish some of these goals data must be available, such as parameters of length of stay and volume of ancillary services prescribed by specific diagnosis, which is reviewed regularly and updated as necessary. Cases in which the services provided to patients differ significantly from the pattern of prevailing practice as reflected by established parameters should be reviewed by hospital utilization review committees to ascertain the appropriateness of such care. The committees should also review cases for possible under-utilization of services, as well.

The patient's physician should be aware of the parameters distributed to the hospitals and in cases in which care exceeds the parameters, the physician should note the reason for such care in the patient's medical record. In cases where care beyond such parameters is provided, information on the necessity of such care should accompany the bill submitted to the insuring financial agencies. Appeals processes should be established to permit reconsideration of instances in which the utilization review committees conclude that services were not medically appropriate.

A Pilot Project is being instituted in several hospitals, particularly in respect to the Federal Employee Program, based on the aforementioned suggestions from the Utilization Task Force. When a patient is admitted to the hospital, a parameter of standards for extended stays (days) will be noted on the chart. This will act as a "flag" for possible overstay of hospitalization. Also, on admission to the hospital a brochure will be distributed to the patients. This brochure will outline to the patient the problems of excessive hospital stays, the workings of a utilization review committee, and a reminder that there are contractual limitations to the days of covered care under his health insurance program.

Upon the patient's discharge, if the stay exceeds the parameters of length of stay, progress notes will accompany the bill. Should this case be found noncoverable under the terms of his contract, the utilization committee, the attending physician, and the administrator will be so notified. Following this determination, if there is disagreement, the medical affairs department of Blue Cross will be contacted. If there is still disagreement, these cases will be sent either to the state medical society or one of its component local societies, as appropriate, for peer review.

This Pilot Project began in several hospitals in November. Concurrently, all acute general hospitals in the state of Maryland were informed of the complete project. It is anticipated that this program will be conducted on an educational basis for approximately six months before actual denials of benefits begin.

The Task Force realizes that overall utilization is of paramount importance today, but it is their feeling that this type of a utilization plan should be first started as a pilot project in a limited number of hospitals. The Task Force intends to continue with its regular meetings to work on refinements of these utilization plans.

In keeping with the suggestions of the Task Force, Maryland Blue Cross and Maryland Blue Shield are developing a more refined computerized analysis of length of stay per diagnosis in the hospitals of Maryland, as well as average charge data per diagnosis. It is anticipated that in the future there will be available average charge data for ancillary services, such as pharmacy, laboratory, physical therapy, and others.

An educational program is being conducted for the general public, jointly sponsored by the Maryland Hospital Association, the Medical and Chirurgical Faculty, Blue Cross, and Blue Shield. It is planned to utilize all communications media, where financially feasible.


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# your medical faculty at work

**by John Sargeant,**
**Executive Director**

**The Faculty's Mediation Committee met on Thursday, Sept 21, 1972 and took the following actions of interest to the membership:**

1) Approved use of professional corporation names as follows:

Prince George's Hospital Radiology Group, PA
Emergency Room Physicians of Annapolis, PA
Chesapeake Physicians, PA

2) Designated a subcommittee to consider the problem of advertising by groups of physicians sponsored by other than third-party carriers.

3) Adopted the following policy with respect to payments for completion of insurance forms:

Completion of Insurance Forms is normally considered a service to the patient. However, where the completion of such forms involves expenditure of time and effort beyond that normally devoted to such activity, it is appropriate for a charge to be made for such work.

If the company requesting such form is a profit-making organization, a charge should routinely be made. If it is a nonprofit corporation, payment may be waived. In all instances, however, it is the physician's prerogative to make a determination as to whether payment should be requested or not.

It is appropriate to seek payment from the patient, if the physician so desires, and the insurance carrier declines or refuses to make a payment to the physician for this service.

4) Endorsed the following policy statement with respect to employment of addicts:

While methadone maintenance is, essentially, a continuation of opiate drug dependence, it does, nonetheless, enable a person who is properly controlled to function adequately in society.

There is a tendency on the part of management to shy away from the employment of persons who are known to be participants in methadone maintenance programs. Despite this, many of these participants are presently gainfully employed. In some instances, their employers are not aware of their participation in a methadone maintenance program.

From a medical viewpoint, the Medical and Chirurgical Faculty of Maryland is concerned that many individuals who, by their participation, have proven they are well motivated but are still unable to obtain employment.

Such individuals are emotionally and medically fit to work or to attend school. Such persons are able to perform all functions within their intellectual and mechanical ability.

The Medical and Chirurgical Faculty strongly urges employers to bear these aspects in mind when considering hiring or continued employment of opiate-habituated persons who are participating in a responsible manner manner in approved drug programs.

5) Declined to intervene in a complaint filed by a physician against a physician for the latter physician hiring away an employee of the former physician.

6) Endorsed the following statement with respect to release of medical information to organizations such as Retail Credit, etc:

The following policy statement was adopted by the Committee:

Physicians should release information to organizations such as Retail Credit only on the written authorization of the patient and only to a specified designee (no release would be accepted if "to bearer").

In cases where organizations such as Retail Credit are involved, an appropriate questionnaire should be developed and used as a standard form. The physician may then have the choice of completing the questionnaire form and signing it. If he elects to dictate the responses to

the questions over the telephone, the company should then send him an original and duplicate, one of which he will sign and return to the company, keeping the other for his records.

Under no circumstances should the physician be asked, nor should he provide answers to extraneous questions.

It is unethical for a physician to provide data or information unless the safeguards mentioned above are observed.

The physician and patient should be aware that the possibility always exists that such medical information may be included with other nonmedical information collected by the company.

It is brought out that there is always the possibility of erroneous data being included in the records, thus the necessity for verification of any spoken information to be transcribed and verified in the manner indicated.

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ART AND HOBBY EXHIBIT

# ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

## APRIL 25, 26, 27, 1973

BALTIMORE CIVIC CENTER

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### APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral St, Baltimore, Md 21201

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height .....

3. Electrical or other requirements: .....

.....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

---

An Art and Hobby Exhibit will be held during the 175th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, April 24. They must be removed on Friday, April 27 between 2:00 and 5:00 PM. The Faculty cannot carry insurance on exhibits, but utmost care will be taken of them. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies will probably cover the exhibit. All entries should be submitted as early as possible.



DANIEL V. LINDENSTRUTH, MD, Editor

*A Service of the Heart Association of Maryland*

**the heart page**

# THE SYNDROME OF MIDSYSTOLIC EXTRA SOUND AND LATE SYSTOLIC MURMUR

WILLIAM E SHELL, MD
Department of Medicine, School of Medicine
University of California, San Diego
La Jolla, Calif 92037

*Information and reprint requests to Dr Shell.*

Mid-late systolic clicks and the associated late systolic murmurs are frequently encountered in clinical practice. Concepts concerning the generation of these auscultatory phenomena have undergone rapid evolution in the last ten years. Traditionally, these sounds were considered to be benign extracardiac events generated by the motion of pleural-pericardial adhesions. However, it is now established that they are related to mild mitral regurgitation and emanate from tension on a large ballooning, redundant posterior mitral valve leaflet. Moreover, in a substantial proportion of cases, there is a strong familial association of mid-late systolic extrasounds and late systolic murmurs indicating a congenital etiology for the valvular abnormality.

## Auscultation

The mid-late systolic extrasound or click is a high-pitched transient, usually best heard at the apex but often radiating widely. The most salient feature is its extreme variability. The sound may vary with position and/or respiration in an unpredictable fashion. Its quality, intensity, and position in the cardiac cycle can vary from moment to moment without provocation. In certain patients the sound is appreciated only in the standing positions, while in others only in the left lateral or the supine position. Thus, careful auscultation will be necessary to detect its presence.

Frequently, there is an associated systolic murmur of mitral regurgitation. In most instances the murmur will be confined to late systole and follow the systolic click. However, pansystolic and midsystolic murmurs also occur with the systolic extrasound and also indicate mitral regurgitation. The murmur also displays some variability, but to a lesser degree than the sound. It may be high pitched and is frequently located at the apex with poor radiation. The murmur, as well as the sound, may be difficult to hear and again careful auscultation is necessary.

## Cineangiocardiography

The cineangiocardiograms in the majority of patients with either systolic extrasounds or late systolic murmurs show a peculiar retroversion of the posterior mitral leaflet during mid-to-late systole. The valve leaflet balloons backward like a sail caught in a strong wind and fills with contrast medium. The systolic extrasound occurs at the height of the excursion of this redundant leaflet. The floppy valve can be easily seen in either oblique position. Frequently, there is a mild degree of mitral regurgitation usually confined to late systole.

## Pathologic Studies

There have been few postmortem examinations reported in patients with these auscultatory phenomena. Barlow reported a man who died suddenly and who had enlarged redundant posterior leaflet with normal chordae tendineae. We have examined the valves of two patients with midsystolic extrasounds, late systolic murmurs,

and abnormal cineangiocardiograms. The findings were similar in both patients. The anterior leaflet area was two to four times larger than normal, while that of the posterior leaflet was four to six times greater than expected. Both patients had extensive deposition of a sulfated mucopolysaccharide in the media of the valve leaflets while the chordae tendineae, as well as the coronary arteries, were normal.

### Clinical Syndrome

The majority of patients with either midsystolic extrasounds or late systolic murmurs are asymptomatic and the auscultatory phenomena are found incidentally. Two major symptom complexes merit discussion. Many of the patients complain of chest pain. The pain is substernal and crushing in quality. It is brought on by exercise but may occur at rest. It lasts minutes to hours and is poorly responsive to nitroglycerin. The pain has been attributed to angina pectoris, coronary insufficiency, myocardial infarction, and noncoronary chest pain depending on which components are most prominent in a particular patient. Coronary arteriograms have been normal in patients studied. The bouts of prolonged chest pain rarely are accompanied by enzyme rises. In a recent study of young females with chest pain, positive exercise tests and normal coronary arteries, 4% had the midsystolic click-late systolic murmur syndrome. The exact etiology of the chest pain is currently obscure.

These patients frequently complain of palpitations. Several types of arrhythmia have been documented including premature ventricular contractions, exercise induced ventricular tachycardia, paroxysmal atrial fibrillation, and paroxysmal atrial tachycardia. Etiology is not entirely clear. Sudden death may occur in patients with the syndrome and among their first degree relatives.

### Electrocardiograms

Electrocardiograms are frequently abnormal in patients with late systolic murmurs and/or mid-late systolic extrasounds. The abnormalities consist of T-wave flattening and inversion in leads II, III, avf, $V_{4-6}$. Evidence of transmural myocardial infarction is seen rarely. Exercise electrocardiograms in patients with chest pain and auscultatory evidence of floppy valves are frequently positive exhibiting ST segment depression despite normal coronary arteriograms. Exercise testing may precipitate arrhythmias, including multiple premature ventricular contractions and ventricular tachycardia. Thus, such tests in patients with the ballooning mitral valve syndrome should be performed with caution and careful monitoring.

### Diagnostic Studies

A number of noninvasive tests may be used to establish the origin of the late systolic murmur as mitral regurgitation. Amyl nitrite administration causes the mid-late systolic extrasound to move earlier in systole frequently merging with the first heart sound. The late systolic murmur also moves earlier in systole and may become pansystolic; its intensity does not change.

Handgrip may be very effective in evaluating these auscultatory phenomena. Handgrip may bring out a systolic extrasound which is evanescent and difficult to document.

Ultrasound examination of the mitral valve often is characteristic in the syndrome. Abnormal motion of the anterior leaflet as well as clear separation of the leaflets on the echogram are common. When present, these signs are nearly pathognomic of the ballooning posterior leaflet syndrome.

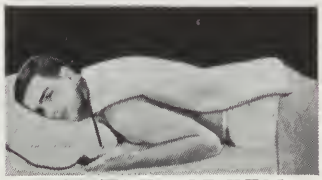
A majority of patients with either midsystolic extrasounds or late systolic murmurs are asymptomatic. Their prognosis for longevity appears independent of the extent of abnormality in the mitral leaflets. However, the occurrence of chest pain and arrhythmias is associated with considerable prognostic uncertainty. The rate of progression of the mitral regurgitation is unknown. Thus, asymptomatic patients with the auscultatory phenomena of the snydrome must be followed periodically.

When chest pain is prominent, treatment with propranolol and long acting nitrates may be initiated. This mode of therapy has afforded significant relief in some patients. Control of arrhythmias is indicated in light of the incidence of sudden death. Ventricular extra systoles should be treated with propranolol and digitalis, while atrial arrhythmias can often be managed effectively with digitalis alone.

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# executive director's newsletter

December 1972

STOLEN RX BLANKS

The Division of Drug Control, Department of Health and Mental Hygiene, has requested all physicians to alert them whenever Rx blanks have been stolen. Forged Rx blanks are appearing more frequently than in the past -- in all categories, hospital, medical assistance, personal, and other.

Pharmacists can be notified of stolen blanks, if this division is promptly informed. Telephone is 383-2729.

PRICE COMMISSION RULING

When a physician becomes newly board-certified, the Price Commission has ruled that fees may be raised to the new base price structure at the level of average base fees charged by other board-certified specialists who practice in this area.

The decision of the commission was based on the reasoning that such professional attainment, "substantially increase the physician's professional status and the value of his services."

FDA RULING

In a recent FDA Drug Bulletin (October 1972), the FDA comments on the use of drugs for unapproved indications. The statement, in part, says:

> "The labeling is not intended either to preclude the physician from using his best judgment in the interest of the patient, or to impose liability if he does not follow the package insert. A physician should recognize, however, that the package insert represents a summary of the important information of the conditions under which the drug has been shown to be safe and effective by adequate scientific data submitted to FDA."

DRUG WARNING

The following acts are illegal under the Pharmacy Code:

DRUG WARNING (cont'd)

"Prescribing any drug without clearly identifying the name of the prescriber on the prescription form and dispensing any drug based on a prescription form which lacks the name of the prescriber."

The above information is brought to the attention of physicians so they may be guided accordingly.

RESOLUTIONS FOR ANNUAL MEETING

Resolutions for the Annual Meeting must be received in the Faculty office before Friday, March 2, 1973, in order to be considered by that House. This is in accordance with Faculty Bylaws, Article XI, Section 26.

FOUNDATION DIRECTORS NAMED

Appointments by the President to complete the 18 members of the Maryland Foundation for Health Care include the following six physicians:

Kenneth Cruze MD - Silver Spring
L. Michael Glick MD - Cumberland
* H. Herbert Insel MD - Silver Spring
Philip A. Insley MD - Salisbury
Charles C. Spencer MD - Hagerstown
R. Lane Wroth MD - St. Michaels

The other 12 members were elected by the House of Delegates at the Semiannual session in Ocean City.

DRUGS AND ALCOHOL

The Subcommittee on Alcoholism recommends to all physicians to instruct patients to whom they are prescribing tranquilizers that they must not drink alcohol in any form during the use of such medication because of the potent and summating effects of alcohol and sedatives. It is also recommended that physicians display a sign in their offices warning patients of the dangers of consuming alcohol while on tranquilizers or sedative medication.

* representing Prince George's County

John Sargeant
Executive Director

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# Health Evaluation Physician Tests







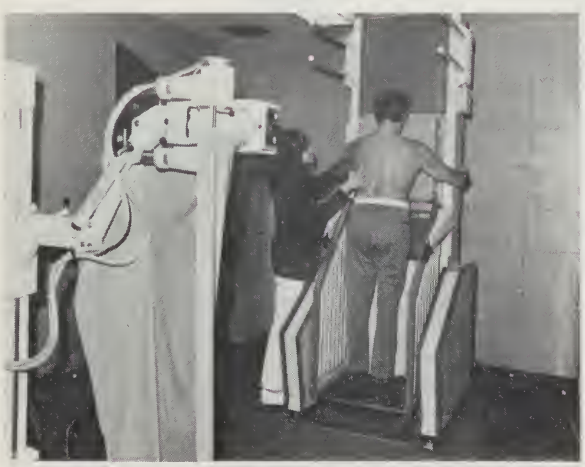
For the past nine years a physicians' multiphasic health testing program has been conducted by Med-Chi, in cooperation with the Maryland Society of Pathologists and other specialty societies, during its Annual Meeting. The program grows in popularity each year; in 1972, 623 completed all or part of the testing.

The services of all physicians and most allied professionals have been volunteered. Because of increasing financial demands associated with equipment, supplies, and certain personnel, a questionnaire was distributed to solicit participants' attitudes both as to assuming part of the program cost and to the desirability of retaining various tests. Results of the responses, reported here, should be of interest to all physicians.

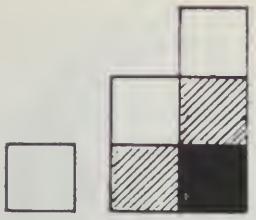
Four representative photos from the 1972 program are pictured. That's Frederick W Bauer, MD, chairman of the Subcommittee for Health Evaluation Tests at the 1972 Annual Meeting at the left of the upper left picture.

Plan now to avail yourself of the opportunity to have this diagnostic screening profile at the 1973 Annual Meeting at the Baltimore Civic Center, April 25-27, 1973. However, this survey is only a complement to an annual examination, Dr Bauer cautions.

| Question Asked | Yes (No & %) | No (No & %) |
|---|---|---|
| Participant willing to pay some HET costs (No replies: 6 or 1%) | 553-89% | 64-10% |
| Should annual HET be continued (No replies: 11 or 2%) | 610-99% | 2-1% |
| Tests to be continued: | | |
| Chest X-rays | 551-98% | 10-2% |
| EKG's | 556-99% | 5-1% |
| Tonometry | 510-91% | 51-9% |
| Chemistry Screen | 557-99% | 4-1% |
| Hematology Screen | 556-99% | 5-1% |
| Urinalysis | 534-95% | 27-5% |







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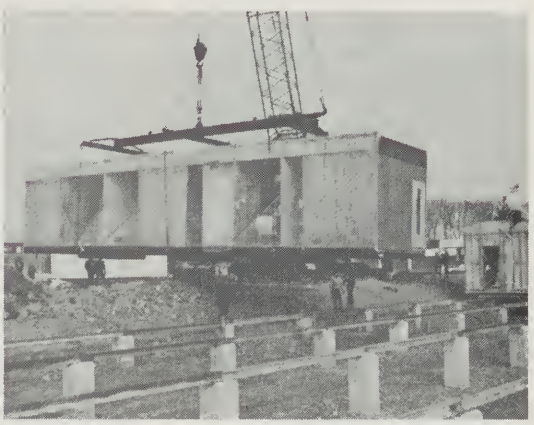
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# MEET YOUR NEW COUNCIL MEMBERS

This month, in the introductory series on new council members, we meet Edwin R Ruzicka, MD. Dr Ruzicka assumed the office of first vice president of the Faculty at the conclusion of the 1972 Annual Meeting on May 5, 1972.

Dr Ruzicka, a native of Baltimore, born April 18, 1914, graduated from Baltimore City College in 1932 and from the University of Maryland, College Park in 1936. He received his MD from the University of Maryland School of Medicine in 1939.

A two-year rotating internship at the University of Maryland Hospital followed from 1939 to 1941. In 1941 he became a Fellow in Anesthesia at the Lahey Clinic in Boston. An interest and clinical reporting on autonomic reflexes and cardiac arrest in the operating room began then.

In the fall of 1942 he went on active duty as a LTJG in the Medical Corps, US Naval Reserve. Duty followed at the USNH, Naval Operating Base, Norfolk and with the 1st Marine Airdrome Battalion at New River, NC. His activities were then shifted at the request of the Bureau of Medicine, USN.

He served as a member of the Surgical Department and as Anesthesiologist at the US Naval Hospital, Pensacola, Fla. While on this duty, he had articles published in the *US Naval Medical Bulletin* and in *Anesthesiology*.

Sea duty followed as a member of the Medical Staff of the USS Lubbock, an attack transport, and participation in the invasions of Iwo Jima and Okinawa. After these operations, he served as Chief of Anesthesia, US Naval Hospital, Aiea Heights, Pearl Harbor and as a member of the Anesthesia Department, US Naval Hospital, Chelsea, Mass. Promotion to LT and to LCDR came before discharge.

In 1946 Dr Ruzicka returned to civilian life as a member of the Anesthesia Staff of the Lahey Clinic in Boston.

Of particular interest was a continuation of the development of a cardiac arrest program, including introduction of electronic monitors and pacemakers. This led to publication of papers on the subject including the great experience of coauthorship with Dr Frank H Lahey of results of his work at the Lahey Clinic. This work was not of research orientation, but dealt with clinical aspects of anesthesiology including some of the early experiences with anesthesia for electro-shock therapy in psychiatry.

By 1958 metropolitan Boston was obviously booming and congested. The Lahey Clinic was also much larger. The Ruzicka family opted for a change and decided on life in a smaller community and in a community hospital where there might be a real need for an anesthesiologist.

Although this search did not include the Eastern Shore of Maryland, a nostalgic trip to Ocean City and a meeting with old friends and classmates led to a decision to enter the practice of anesthesia at the Memorial Hospital, Easton, Md.

He is still there and has been active in developing a Respiratory Care Service and has served on many hospital staff committees.

Since 1948 Dr Ruzicka has been a Diplomate of the American Board of Anesthesiologists, and a Fellow of the American College of Anesthesiologists. Other memberships include the International Anesthesia Research Society, Maryland-Virginia Society of Anesthesiologists, Southern Society of Anesthesiologists, and the Maryland Thoracic Society.



**Dr Ruzicka**

He also holds memberships in the AMA, Med-Chi, Talbot County Medical Society, the Southern Medical Society, and is an associate member of the Massachusetts Society.

Dr and Mrs Ruzicka live on the Tred Avon River in the Waverly section near Easton. They have three children and three grandchildren. Linda, now Mrs William Huxtable, an honor graduate of the University of Delaware, lives in Wilmington and is the mother of two daughters.

Tom, a member of the Army Security Agency and trained in the North Vietnamese dialect, is in Vietnam. He is a graduate of the University of Maryland, College Park. He has written that he would like to try for a Texas med school.

Eileen, the mother of one daughter, lives on the Eastern Shore not too far from Easton and visits her family often.

# Doctors in the News

**Albert I Mendeloff,** MD, physician-in-chief at Baltimore's Sinai Hospital, was recently named president-elect of the American Gastroenterological Association. He becomes president in May 1973. The Association is the oldest medical specialty society in the United States.

Dr Mendeloff, a graduate of Princeton University and of Harvard Medical School, is also professor of medicine at the Johns-Hopkins University School of Medicine. He served as 1958-1959 president of the American Federation for Clinical Research.

•

The new president of the Somerset County Medical Society is **James A Sterling,** MD. He succeeds **Arthur Norman Barr,** MD, who died September 1.

•

Members of the Maryland Academy of Family Physicians who have become board certified by the American Board of Family Practice in 1972 include these physicians, all MDs:

**Morton Altschuler, James Brown, Edward Wilson Ditto III, Michael R Dobridge, Morton J Ellin, C Earl Hill, David L Hoff, Klaus Hermann Huebner, Edward Joseph Kowalewski.**

Also, **George H Mitchell, Allen Wesley Morrisey, Irvin H Moss, Hubert F Manuzak, Donald E Martin, Donald L McKinney, Paul Taylor Noone, Bennett A Porter Jr, Margaret T Snow, Elizabeth A Turner, William Chodoff Weintraub, Frederick Henry Wilhelm, Anne Zevallos.**

Congratulations to all of you!

**Robert J Wilder,** MD, Baltimore cardiovascular surgeon, has been named "honorary instructor emergency medical technician-ambulance" by Neil Solomon, MD, Maryland's secretary of Health and Mental Hygiene.

The award of a certificate and shoulder patch was made in recognition of Dr Wilder's services to the Emergency Care Advisory Council.

Dr Wilder represents Med-Chi on the Council.

•

**J Brett Lazar,** MD, has succeeded **Theodore Shrop,** MD, as Howard County Health Officer. Dr Shrop retired on reaching his 70th birthday.

Dr Lazar, a Columbia resident, had served as Carroll County Health Officer since June 1970.

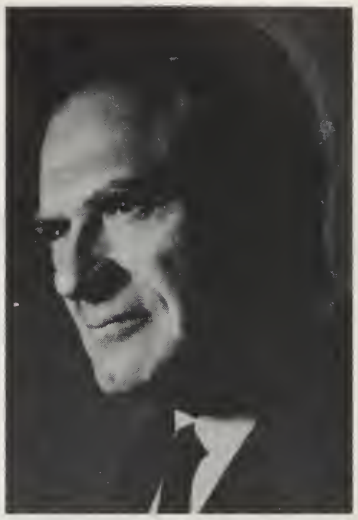
Dr Shrop had been in charge of the Howard County Health Department since 1946.

•

According to *Volunteer Physicians for Viet Nam,* an AMA publication, 100 physician volunteers are needed in 1973. Information can be secured from the Office of the Program Director, Volunteer Physicians for Viet Nam, AMA, 535 N Dearborn St, Chicago, Ill 60610.

The publication also added these Maryland volunteers to the honor roll:

**Robert Ellwood Eby, Andre V Fesus, Michael B Flynn, Wayne K Foster, David F Goldstone, Stephen M Nagy Jr, Louis Padovano, Thomas Hooker Powell, Glendon E Rayson, Patrick A Reardon, Donald K Wallace, and Celeste L Woodward.**



**Dr Seligman**

**Arnold M Seligman,** MD, chief of the department of research oncology and cell biology at Baltimore's Sinai Hospital, has been named Maryland Chemist of the Year by the American Chemical Society.

He is the first surgeon to be given this distinction. The award honors a member who has made outstanding contributions to the field of chemistry.

A reception and banquet preceded the award ceremony at which Dr Seligman delivered a lecture on his program for the development of cytochemical methods for the electron microscope.

Dr Seligman is credited with a number of chemical firsts: creation of the historically important, cancer-inducing agent, methylcholanthrene; induction of experimental brain tumors; clinical use of synthetic vitamin K; successful use of peritoneal irrigation for uremia; preparation of radioactive iodoprotein; development of several new viochemical and histochemical methods; and the developments of rapidly detoxified chemotherapeutic agents for certain patients with advanced cancer.

**Roland T Smoot,** MD, a Baltimore internist, has been elected to the Maryland Blue Shield Board of Directors.

•

**C Alex Alexander,** MD, director of medical affairs at Baltimore's Provident Hospital, announces the following appointments:

**William W Quivers,** MD, as full-time chief of pediatrics. Dr Quivers comes to Baltimore from Winston-Salem, NC where he was associate professor in the department of pediatrics at the Bowman Gray School of Medicine.

**Arthur Lamb,** MD, as full-time chief of psychiatry. Dr Lamb is assistant professor of psychiatry at the University of Maryland.

**Boon Vanasin,** MD, as associate director of medical education. Dr Vanasin is a Fellow in medicine at the Johns Hopkins Hospital.

**Mohamad Shafi,** MD, as associate in medicine (cardiology).

**Rifat Abousy,** MD, as associate in cardiology.

•

Two distinguished Baltimore physicians have been added to the Provident Hospital Board of Trustees. They are **John H Moxley III,** MD, dean of the University of Maryland School of Medicine, and **Frank Furstenberg,** MD.

•

**Gilbert D Barkin,** MD, Montgomery County, has been elected to the Board of Regents of the American College of Allergists. He has also been appointed to the Board of Directors of the Regional Chapter of the Allergy Foundation of America.

**Maxwell N Weisman,** MD, director of the division of alcoholism control of the Maryland Department of Health and Mental Hygiene, has been elected president of the American Medical Society on Alcoholism Inc.

Dr Weisman was also recently elected vice president of the Alcohol and Drug Problems Association of North America.

•

**Beverly Myers,** MD, has been named assistant professor of pediatrics at the Kennedy Institute for Handicapped Children and the Johns Hopkins University School of Medicine. Dr Myers comes to Baltimore from the Medical College of Wisconsin.

•

**Spencer Foreman,** MD, has been named director of the US Public Health Service Hospital in Baltimore.

A US Public Health Service Commissioned Corps career physician, Dr Foreman entered the service as a staff physician in California in 1962.

He was named acting director of the Baltimore hospital in August 1971 while concurrently holding the post of chief of the department of internal medicine.

The Philadelphia native received his MD from the University of Pennsylvania.

•

**George Samaras,** MD, and **Michael Grasso,** MD, have been appointed chief residents in medicine at Maryland General Hospital in Baltimore for 1973-1974.

Both are 1970 graduates of the University of Maryland Medical School.

**Barton J Gershen,** MD, Montgomery physician, has been elected president of the executive board of the Montgomery Heart Association.

•

Twenty-three Maryland doctors were among 1,527 initiates inducted as new Fellows of the American College of Surgeons during the 1972 annual Clinical Congress.

Fellowship, a degree entitling the recipient to the designation FACS following his MD, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery.

The Maryland list includes **Adeleke Adeyemo,** Annapolis; **William G Plavcan,** Hagerstown; **Dino E Flores,** Rockville; and **LtCol Monroe I Levine,** MC USA, College Park.

Recipients from the Greater Baltimore area included **Robert K Brawley, Edward O Hunt Jr, Michael E Jabaley, Juan M Juanteguy, Jay N Karpa, J Donald McQueen, David R Morales, Sylvester Sterioff Jr, Chris P Tountas, Melvin M Friedman,** and **Jose F Morelos.**

From Silver Spring came **Stephen Epstein, Jochim A K Kluger, Col Bernard T Mittemeyer,** MC USA, **Giulio I Scarzella,** and **Halketh Lyndon Marter.**

Chevy Chase doctors included **Richard H Conant, Frederick J Frensilli,** and **George W Jones.**

Congratulations, all!

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**APRIL 25, 26, 27, 1973**

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# MEDICINE IN MARYLAND-175th ANNIVERSARY ANNUAL MEETING MEDICAL AND CHIRURGICAL FACULTY

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- **ART AND HOBBY EXHIBIT**
- **HOSPITALITY NIGHT**

MORE ABOUT THE PROGRAM NEXT MONTH

SEE PAGE 88 FOR APPLICATION FOR SCIENTIFIC EXHIBITS

**Albert M Antlitz, MD, Chairman**
**Committee on Program and Arrangements**

# Medical Miscellany

## Howard County Hospital Dispute

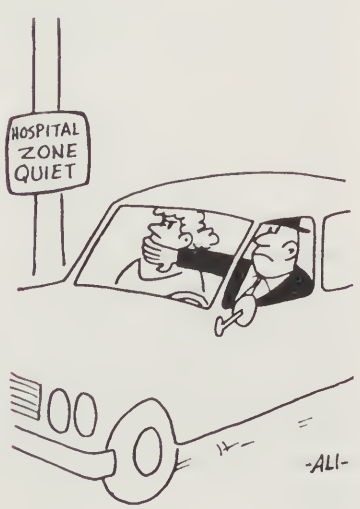
Citing as specious reports of projected losses for St Agnes Hospital and Suburban Hospital in Montgomery County should an additional Howard County general hospital facility be built, Paul A Mullan,MD, Public Relations Chairman of the Medical and Chirurgical Faculty, in a recent press conference, pointed out that the same cry had been raised by Blue Cross in 1965 when the Baltimore County General Hospital was alleged to be surplus to the needs of the community.

"At that time," he stated, "the residents of the community had to seek assistance from the General Assembly in order for the institution to be recognized by Blue Cross and to pay for hospital stays at that facility."

In clarifying his remarks, Dr Mullan pointed out that only recently Baltimore County General Hospital has been given approval of an expansion program to increase the number of beds to serve this rapidly growing area. Had the institution closed its doors because of the threat of Blue Cross payment denial, this area of the county would not now be served by a viable and growing institution.

"It hardly seems conceivable that in less than seven years the Baltimore County General Hospital has become essential to the community when Blue Cross indicated it was not necessary, would have empty beds, and would increase the overall costs of medical care to the community residents," he said. While the Faculty completely agrees that rarely used services such as cobalt therapy should not be provided in all institutions, it does recognize and strongly support the need for general hospital facilities with a complete range of services in any community without the residents having to travel many miles, and without their being restricted in the institutions to which they can go for medical assistance.

Dr Mullan went on further to state that the Faculty did not support any particular group's application for permission to build a general hospital, but did support the concept that Howard County residents should not be denied what other county residents in the metropolitan area already have.




## Medical Enrollment Sets Record

A record 44,000 students enrolled in the nation's 112 medical schools this year, according to figures in a recent issue of *American Medical News*.

Estimates by the Association of American Medical Colleges indicate that 37% of 36,500 applicants were accepted for 13,000-plus openings in the first-year class. Organized medicine's goal is a 50% acceptance rate.

The number of accepted candidates surpassed the 12,000-plus entering class of a year ago. Total 1971 enrollment of 43,399 was topped.

Applications indicate that PhDs, lawyers, and others in various professional ranks are applying to medical schools.

New schools, opened this fall include Mayo Medical School, Mayo Foundation, Rochester, Minn, University of Minnesota-Duluth Medical Education Program, a two-year program which will eventually expand to four years, and Texas Tech University School of Medicine, Lubbock.

A fourth, Southern Illinois University School of Medicine in Springfield, opens in the summer of 1973, and a fifth school, the University of South Alabama Medical College, opens in January 1973.

## Baltimore County Launches Pilot Ambulance Program

An innovative pilot program aimed at dramatically reducing loss of life due to heart attacks began recently in Baltimore County.

County Executive Dale Anderson has lauded the Baltimore County Fire Department and the Bendix Field Engineering Corporation for pioneering the Mobile EKG Telemetry System. He also praised Baltimore City Hospitals officials for their cooperation in planning the program and training personnel.

Anderson cited County Ambulance Service statistics which show that half of the 1,300 heart cases transported annually to area hospitals die on the way to a hospital.

Of these 600 patients, indications are that over 300 will live, and about 20% will be restored to entirely normal lives through use of the Telemetry System.

A radical departure from any system presently in use in the United States, this approach utilizes air waves, electronics, and human ingenuity.

It is unique in that it will allow any Baltimore County Fire Department ambulance crew to transmit and receive data to any of seven area hospitals, and to treat a heart patient while enroute to that hospital.

Once in the ambulance, victims will have the seriousness of their attack diagnosed by a doctor who receives the vital heart data at the hospital via radio and telephone lines. After evaluating the information, the doctor prescribes the treatment to be administered by the attendant in the ambulance while enroute.



LIFE SAVING EQUIPMENT—Ralph R Vanderlipp (left) of the Bendix Field Engineering Corporation inspects the EKG Telemetry System with Baltimore County Fire Chief J Austin Deitz.

Upon successful completion of the pilot program, presently involving two ambulances and Baltimore City Hospitals, six other area hospitals and 11 ambulances are slated to be equipped and added to the system. It is expected to take about 18 months to make the program fully operative.

In addition to City Hospitals, other hospitals to participate include St Joseph, Greater Baltimore Medical Center, Franklin Square, Baltimore County General, Sinai, and St Agnes.

Ambulance equipment consists of an electrocardiogram, with two small metal leads to be attached on the patient (three if the doctor so determines); a data scope to show the hook-up has been made properly; a component to convert the vital heart information to a radio signal; and a multi-switch receptacle with a hospital designation over each stop.

Leading cardiologists in the metropolitan area of Baltimore are conducting the educational programs for ambulance personnel so that they may recognize the symptoms of a heart attack patient and properly use advanced telemetry equipment. This service is donated by the doctors, including inservice hospital training.

In addition to Gustav Voight, MD, chief of the cardiovascular division at Baltimore City Hospitals, Robert Wilder MD, fire department surgeon and assistant professor of cardiology at Johns Hopkins Hospital, has contributed many volunteer hours to this effort.

Also working selflessly to make the program a reality are Robert Kent, MD, Greater Baltimore Medical Center; Kenneth Lewis, MD, Franklin Square Hospital; and Raymond Bahr, MD, St Agnes Hospital.

## Lecture Award

The American Association for the Study of Headache has announced the 8th Annual Harold G Wolff MD Lecture Award.

It will be awarded to the physician who submits the best original paper on headache, head pain, or on the nature of pain itself.

The paper may be concerned with basic research, clinical studies, or both. All physicians are eligible.

A prize of $1,000 will be awarded and the winner will be invited to present the paper at the annual AASH meeting in New York in June.

Papers should be submitted to Donald J Dalessio, MD, University of Kentucky, College of Medicine, Lexington, Ky 40506 before March 15.

## Family Practice Grants Received

The family practice program of the University of Maryland School of Medicine has been awarded two grants totaling nearly $400,000 from the Department of Health, Education, and Welfare to expand the training of medical students and residents.

One, a $283,738 grant, will enable medical students to work with practicing family physicians in a community setting.

Acting as preceptors will be selected physicians in family practice, pediatrics, and internal medicine, who practice in rural or inner city areas with a severe shortage of physicians, explained Roy Guyther, MD, director of the preceptorship program and associate professor of family practice.

For a period of two or three months a student will leave the medical school setting to work with his preceptor to gain an awareness of a medical way of life of a family physician in private practice. The program, said Dr Guyther, is also designed to help the student see the need to understand each patient "in relationship to his family, his job, and his total environment."

By observing the practicing physician in his working environment, students will be afforded insights into the patient-physician relationship and the varied scope of the family physician's work.

The family practice program has offered a limited preceptorship program in previous years with the help of contributions from the Maryland Academy of Family Physicians, local medical societies, and student organizations, but the federal grant will make it possible for up to 50 students a year to participate in a family practice preceptorship.

The second grant provides $107,840 for training residents in the family practice program. Much of the money is being used in setting up a model family practice office and establishing research capabilities.

Leroy T Davis, MD, director of residency training and associate professor of family practice, said an administrative assistant will be hired to organize and conduct the model family practice business office, in which each resident will spend an allotted amount of time during the three-year residency.

Other new staff members to be added to the innovative family practice program are a medical social worker, a clinical pharmacist, an epidemiologist, medical records librarian, a medical research technician, and a dental staff, all of whom will be part of the program's team approach to health care. Particularly the pharmacist, who will teach residents practical therapeutics, and the research technician, who will analyze laboratory procedures and medical record-keeping, are new types of role in a medical practice.

The model business office will include computerization of patient records in order to make information most accessible and to make epidemiological study possible. Another objective is to instruct residents in the use of computerization as well as other record-keeping systems. Computerized record-keeping will also be used to analyze what each resident does.

The training grant will also provide funds to bring in medical consultants to discuss specific topics with the residents. In addition, residents will be enabled to participate in courses and conferences held at other locations in the country.

Commenting on the practical emphasis of the residency training program, Dr Davis said, "Our primary function is to prepare our residents to go into practice and handle 90% of the medical problems that come to them." While the program does not train its residents to be surgeons, it does stress basic surgery, and applicable minor surgery, life-saving procedures for shock and trauma victims.

Further practical training is gained in the third year, when the resident acts as a locum tenens practicing with a physician or group in a community similar to that in which the resident intends to practice.

Currently, eight residents are being trained in the family practice program, and next year the number is expected to expand to 20.

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**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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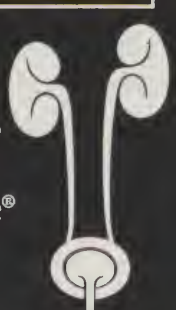
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ROBERT E. FARBER, MD, MPH, Commissioner

Baltimore City
health department

# Advisory on Animal Bites

The following guidelines and epidemiological information for the treatment of animal bites occurring in Baltimore City was sent to physicians recently by the Baltimore City Health Department.

1) The **routine** use of rabies vaccine for dog bites in Baltimore City is not recommended. However, it is important to determine if the biting animal exhibited any bizarre activity which can be symptomatic of rabies. Unprovoked attacks by dogs and wild animals such as skunks, foxes, raccoons, and bats are more likely to be infective. Rodent bites such as those caused by rats, mice, squirrels, chipmunks, rabbits, gerbils, and hamsters ordinarily need no antirabies treatment.

2) There is an increasing incidence of rabies in bats in Maryland. Any person bitten by a bat should be given a full course of both rabies vaccine and antirabies serum at once regardless of laboratory examination of the bat.

3) Rabies virus is usually carried in the saliva and enters the body through wounds in the skin or through unabraded mucous membranes. An excellent antirabies measure is immediate copious flushing of the wound with a soap or detergent solution. Antitetanus or other antibacterial measures are advised for general wound treatment. Bites through clothing are less likely to infect the wound with rabies virus.

4) Do not begin antirabies treatment if the animal is healthy at the time of the bite and the wound is not severe. The biting animal, however, should be kept under surveillance until pronounced rabies-free by a veterinarian after ten days. Wild animals, if caught, should be sacrificed and the detached head delivered to the Maryland State Laboratory, 16 E 23rd St, in a sealed plastic bag. Evenings and weekends the head may be taken to the first floor, Municipal Office Bldg, for delivery to the Health Department Laboratories.

5) In contemplating the use of rabies vaccine or antiserum, the physician should consider the possibility of adverse reactions. Nervous tissue vaccine (NTV), prepared from rabbit brain tissue, is more likely to cause neuroparalytic reactions than the Duck Embryo Vaccine (DEV). The physician should question the patient as to his sensitivity to either avian or rabbit tissue allergy. The hyperimmune antirabies serum is a horse serum product and a careful history must be obtained and appropriate tests for hypersensitivity performed. Rabies vaccine and serum can be obtained from the Maryland State Department of Health and Mental Hygiene, General Services Division, phone 383-2680, **following authorization from the Baltimore City Health Department.**

6) The law requires that all animal bites occurring in Baltimore City be reported to the Baltimore City Health Department, 752-2000, ext 313, or to the nearest police station.

## Evaluating Bite Cases

In deciding whether or not antirabies treatment should be given, the following should be considered.

a) The species of biting animal, its health status, its rabies vaccination status and whether or not it is now in captivity.

b) The circumstances at the time of the bite. A rabid animal is more apt to bite without provocation.

c) Type of exposure. 1) **Bite wounds** in which the patient may be exposed to rabies by penetration of the skin by teeth and 2) **nonbite wounds** in which the patient has scratches, lacerations, or abrasions which may be contaminated by saliva.

## Rabies Epidemiology

1) Human rabies is a rare disease. Less than five cases of human rabies have occurred in the whole country in any single year since 1959; the total for 1971 was two. The last case of human rabies in Baltimore City occurred in 1930.

2) The incidence of rabies in animals is not known. However, 4,392 rabid animals were identified in the US in 1971. Skunks, foxes, bats, and cattle constituted more than 80% of the rabid animals reported. Bat rabies was reported in 47 states, skunk rabies in 32, fox rabies in 31, and rabies in cattle in 28 states.

Bats constitute the principal known reservoir of rabies virus in Maryland and probably the main rabies hazard to humans. The three rabid bats in Maryland were found in 160 bat examinations. Dogs, the principal offenders of bites of humans, do not appear to be infected. Only five rabid dogs were identified in the state within the past ten years. The last rabid dog found in Baltimore was in 1947.

Additional information on the treatment of animal bites may be obtained by calling Dr David R Berzon, public health veterinarian in the Baltimore City Health Department, 752-2000, ext 315.

**Table 1: Animals Identified as Rabid in Maryland and Nearby Areas — 1971**

| | Dog | Cat | Cattle | Other Domestic | Fox | Skunk | Bat | Raccoon | Other Wild | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Maryland | — | — | — | — | — | — | 3 | — | — | 3 |
| Delaware | — | — | — | — | — | — | 4 | — | — | 4 |
| Pennsylvania | 3 | — | 2 | — | 4 | 4 | 10 | — | — | 23 |
| Virginia | 2 | 4 | 2 | 4 | 63 | 3 | 1 | — | — | 79 |
| West Virginia | 34 | 15 | 14 | 4 | 48 | 3 | 1 | 1 | 1 | 121 |
| Dist of Columbia | — | — | — | — | — | — | — | — | — | — |
| New York | — | 4 | 20 | 3 | 59 | 20 | 29 | — | 1 | 136 |
| Ohio | 16 | 1 | 9 | 1 | 19 | 70 | 6 | 1 | — | 123 |
| Kentucky | 26 | 8 | 27 | 3 | 96 | 23 | 2 | 1 | 1 | 187 |


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*—George Sarton, from "The History of Medicine Versus the History of Art"*

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

# Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

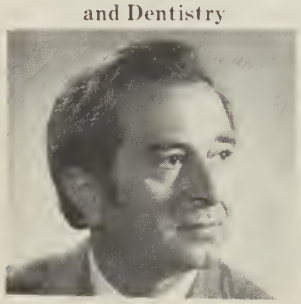
13.8%
Do not believe combination drug products are useful.

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

## Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years and that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin - streptomycin combinations that patients—especially surgical patients—were given in one injection. This made for less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such a preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injections (rather than the proper use) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.

# Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the *usual* dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

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# AN INTERIM PROGRAM FOR EMERGENCY PSYCHIATRIC EVALUATION IN BALTIMORE CITY

**ALAN H PECK, MD**
**Route 1, College Park**
**Lewisburg, Pa 17837**

*Information and reprint requests to Dr Peck, who was resident in the Department of Psychiatry, Institute of Psychiatry and Human Behavior, University of Maryland Hospital, when this was written.*

An Interim Program was organized in the City of Baltimore to provide emergency evaluation of its mentally ill population by psychiatric residents of the Institute of Psychiatry and Human Behavior of the University of Maryland Hospital in Baltimore. It was originally intended to function for four months until a permanent screening and evaluation unit could be operating efficiently in the city.

## History

This Interim Program, as with all previous efforts, continued to be performed in police lockups since this was the only facility available. To be evaluated in such a facility, these people must have been charged with a crime, taken before a judge in a District Court, and either be sentenced to jail, released, committed to a state hospital, or referred to the lockups for this evaluation.

The program replaced one in which this population was examined for years by semiretired general practitioners who had no formal psychiatric training. Although there were no figures available it was the feeling of Addison Pope, MD, of the Department of Mental Health, and Sergeant Hanson of the Police Department that they committed many of the patients evaluated without utilizing community resources for referral. For several reasons, some of them personal, they terminated their duties in July 1970. For two months people arrested were either evaluated by other doctors available in the community or taken directly to state hospitals when no one was available for evaluation. There was one attempt to have these people evaluated at the Institute of Psychiatry and Human Behavior. The first person seen was clearly the victim of an oedipal struggle with the stepfather wanting him out of the house. It became apparent to the residents that if it had not been for their intervention, the boy would have been committed with a criminal record to a state hospital with all the negative sequelae.

This evaluation occurred only once since the police found it too difficult and potentially dangerous to transport some of these people more than necessary. When the residents learned that once again these people might be taken directly to state hospitals, they began to work for some type of program where the people could be evaluated fairly in the lockups until the receiving hospital could be functioning. Along with the sources and assistance of the Department of Mental Hygiene and Department of Social Services of Baltimore City, and with permission from their Institute, some psychiatric residents from the Institute of Psychiatry and Human Behavior began interviewing patients at the lockups on September 30, 1970 on a daily basis. Several residents refused to partake in the program because they felt the concept of incarceration was unfair and morally wrong and they could not support the program. The others saw this only as an interim situation which at least now would allow the mentally ill to be evaluated by trained people.

At first there were numerous difficulties; but, considering the vast change of such a program, they were minor, including some scheduling conflicts, gaining the trust and confidence of a leery police department which had witnessed the failure of so many programs, and learning to work together with a new staff. An evaluation unit made up of mental health technicians would first see the patients and obtain a complete social, mental, and physical history and observe obvious mental symptoms. They would contact the family, friends, or hospitals and gain any other information from whomever may have accompanied the patient to the lockup. The information would be placed on a form which would include all the pertinent information and be presented to the two residents along with the police and court

records. The residents would then interview the patient (unfortunately in the cell) to obtain a more complete mental status and to understand the present circumstances which brought him to the lockup, and finally would talk to the family whenever present and then would either commit to a state hospital or send the patient back to court.

As the team became more knowledgeable of local facilities, they would commit to private hospitals and later were able to persuade the judges to write "do not return to court" for those people whose charges would be dropped. The doctors could now refer additional people directly to community facilities such as halfway houses. For those which had to return to court, a letter was sent to the judge informing him what facility might be best for the man with the hope that the judge would drop charges or use these suggestions as a condition of parole. When it was felt that the patients had absolutely no motivation, no referrals were made leaving the final decision up to the judge alone. If the patient required medical attention or tranquilizing and/or seizure medicine, the doctors were not able to attend to this and the patient would be taken by paddy wagon to a local emergency room. Unfortunately they would be held overnight in the lockup and evaluated by different residents the next day.

## Results, Discussion

As of Dec 31, 1971, 15 months after the program had begun, almost 5,000 people have been evaluated. The best way the author feels to evaluate such a program is 1) to compare the old program which included the general practitioners with the present program and 2) to observe subtle changes and trends which have occurred within the program since it was so much more complex than what was previously offered. The records kept during the Interim Program are extensive; subtle changes should be easily evident; previous records were unfortunately poor and some were impossible to obtain or did not exist. With this in mind, it was not possible to compare all facets of this program to those of previous programs as one would have liked. However, those figures which are available and which do show this comparison should help demonstrate the effectiveness of this program.

The mentally ill female patients were evaluated at the Pine St Station (later Northeast Station). Table 1 charts the number of people, both alcoholic and psychiatric, committed to Maryland State Hospitals from Pine St Station in 1969 by the general practitioners; this averages 62.2 patients a month. Once again, it is assumed that this includes many of the patients evaluated by the general practitioners although the actual figures of the percent are unobtainable. There are no records available concerning the male population examined at the Southwestern lockup in 1969. From experience, however, approximately three to four times as many males are seen daily and there is no reason not to assume that this many times of males were committed. (According to the Baltimore City Police Department, 1,823 males were examined by the general practitioners at Southwestern in 1967 and 1,904 in 1968.)

**TABLE 1: Pine St Lockup**

**Females Committed to Mental Institutions in 1969****

| Month | Crownsville* | | | Springfield* | | | Spring Grove | | | Total | | Grand |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | W | B | TTL | W | B | TTL | W | B | TTL | W | B | Total |
| Jan | 18 | 15 | 33 | 8 | 13 | 21 | 13 | 7 | 20 | 30 | 35 | 74 |
| Feb | 14 | 10 | 24 | 5 | 10 | 15 | 9 | 8 | 17 | 28 | 28 | 56 |
| Mar | 6 | 4 | 10 | 0 | 8 | 8 | 4 | 1 | 5 | 10 | 13 | 23 |
| April | 13 | 7 | 20 | 6 | 10 | 16 | 8 | 5 | 13 | 27 | 22 | 49 |
| May | 17 | 12 | 29 | 9 | 15 | 24 | 13 | 6 | 19 | 39 | 33 | 72 |
| June | 18 | 20 | 38 | 9 | 25 | 34 | 9 | 4 | 13 | 36 | 49 | 85 |
| July | 14 | 18 | 32 | 8 | 23 | 31 | 7 | 8 | 15 | 29 | 49 | 78 |
| Aug | 13 | 16 | 29 | 7 | 17 | 24 | 10 | 12 | 22 | 30 | 45 | 75 |
| Sept | 13 | 10 | 23 | 8 | 17 | 25 | 6 | 5 | 11 | 27 | 32 | 59 |
| Oct | 15 | 12 | 27 | 6 | 17 | 23 | 11 | 3 | 14 | 32 | 32 | 64 |
| Nov | 13 | 5 | 18 | 6 | 14 | 20 | 6 | 5 | 11 | 25 | 24 | 49 |
| Dec | 17 | 10 | 24 | 6 | 15 | 21 | 5 | 9 | 14 | 28 | 34 | 62 |
| **Total** | **171** | **139** | **310** | **78** | **184** | **262** | **101** | **73** | **174** | **350** | **396** | **746** |

* Maryland State Hospitals

** Courtesy—Baltimore City Police Department

**TABLE 2: Pine St Lockup**

**Females Committed to Mental Institutions in 1971***

| Month | Crownsville | | | Springfield | | | Spring Grove | | | Total | | Grand |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | W | B | TTL | W | B | TTL | W | B | TTL | W | B | Total |
| Jan | 5 | 2 | 7 | 8 | 8 | 16 | 7 | 3 | 10 | 20 | 15 | 33 |
| Feb | 7 | 7 | 14 | 8 | 3 | 11 | 6 | 1 | 7 | 21 | 11 | 32 |
| Mar | 9 | 6 | 15 | 8 | 5 | 13 | 4 | 3 | 7 | 21 | 14 | 35 |
| April | 4 | 2 | 6 | 7 | 11 | 18 | 9 | 4 | 13 | 20 | 17 | 37 |
| May | 6 | 9 | 15 | 10 | 11 | 21 | 5 | 0 | 5 | 21 | 20 | 41 |
| June | 11 | 7 | 18 | 2 | 11 | 13 | 4 | 2 | 6 | 17 | 20 | 37 |
| July | 8 | 7 | 15 | 8 | 10 | 18 | 7 | 1 | 8 | 23 | 18 | 41 |
| Aug | 9 | 8 | 17 | 8 | 13 | 21 | 4 | 2 | 6 | 21 | 23 | 44 |
| Sept | 6 | 14 | 20 | 7 | 9 | 16 | 2 | 5 | 7 | 15 | 28 | 43 |
| Oct | 8 | 2 | 10 | 5 | 5 | 10 | 3 | 6 | 9 | 16 | 13 | 29 |
| Nov | 3 | 5 | 8 | 5 | 2 | 7 | 5 | 2 | 7 | 13 | 9 | 22 |
| Dec | 2 | 1 | 3 | 3 | 10 | 13 | 3 | 1 | 4 | 8 | 12 | 20 |
| **Total** | **70** | **78** | **148** | **79** | **98** | **177** | **59** | **30** | **89** | **216** | **198** | **414** |

* Courtesy—Baltimore City Police Department

**Table 3: Number of Alcoholic Evaluations**

**Males and Females — Interim Program***

| Date | Total Pts Eval | M | F | Disposition | | | | | | Evaluators | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Crownsville | Springfield | Spring Grove | Total Committed | Back to Court | Comm. Agency or no referral | Physicians | Judges 3 |
| Dec 70 | 123 | 116 | 7 | 36 | 41 | 16 | 93 | 13 | 17 | 57 | 66 |
| May 71 | 145 | 135 | 10 | 43 | 29 | 34 | 106 | 3 | 36 | 79 | 66 |
| June 71 | 150 | 140 | 10 | 55 | 32 | 35 | 122 | 3 | 25 | 68 | 82 |
| July 71 | 152 | 135 | 17 | 38 | 31 | 37 | 116 | 9 | 37 | 80 | 72 |
| Aug 71 | 162 | 148 | 14 | 49 | 39 | 31 | 119 | 12 | 31 | 94 | 68 |
| Sept 71 | 125 | 109 | 16 | 39 | 26 | 23 | 88 | 10 | 27 | 62 | 63 |
| Oct 71 | 122 | 103 | 19 | 30 | 34 | 18 | 82 | 10 | 30 | 74 | 48 |
| Dec 71 | 104 | 87 | 17 | 24 | 18 | 12 | 54 | 12 | 38 | 82 | 22 |

**Table 4: Number of Psychiatric Evaluations**
**(including normals, retarded, and geriatric)**

**Males and Females — Interim Program***

| Date | Total Pts Eval | M | F | Disposition | | | | | | Evaluators | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Crownsville | Springfield | Spring Grove | Total Committed | Back to Court | Comm. Agency or no referral | Physicians | Judges 3 |
| Dec 70[1] | 123 | 80 | 43 | 45 | 30 | 15 | 90 | 13 | 20 | 118 | 5 |
| May 71 | 167 | 110 | 57 | 48 | 51 | 28 | 127 | 4 | 36 | 138 | 29 |
| June 71 | 125 | 83 | 42 | 47 | 37 | 5 | 89 | 6 | 30 | 109 | 16 |
| July 71[2] | 121 | 74 | 47 | 34 | 29 | 15 | 78 | 11 | 32 | 112 | 9 |
| Aug 71 | 114 | 70 | 44 | 31 | 30 | 14 | 75 | 18 | 21 | 101 | 13 |
| Sept 71 | 103 | 74 | 29 | 37 | 30 | 14 | 81 | 7 | 15 | 95 | 8 |
| Oct 71 | 93 | 68 | 25 | 24 | 25 | 13 | 62 | 14 | 17 | 87 | 6 |
| Dec 71 | 96 | 74 | 21 | 26 | 35 | 3 | 64 | 13 | 19 | 93 | 3 |

* Tables 3 and 4 courtesy of State of Maryland Department of Mental Hygiene and A Narciso

1 Rosewood Referrals—Dec 70, and Dec 71 (Maryland State Hospital for Mental Retardation)

2 Includes one referred to Clifton T Perkins Maximum Security Facility

3 Directly committed without referral to physicians

In comparison to this, the police figures for females committed in 1971 during which time the Interim Program was functioning are listed in Table 2. This demonstrates that 414 females were committed to state hospitals with the lowest number occurring in December at only 20. The average committed per month was 34.5 patients, a decrease of 27.7 people or 43.6%. Again, this includes both alcoholic and psychiatric patients.

The remaining charts and figures deal with the subtle changes and improvements which have occurred within the program. In Tables 3 and 4, the patients evaluated are broken down as to alcoholic and psychiatric, the latter including several patients considered normal, mentally retarded, and geriatric. These charts include people court-committed by the judges without referral to physicians. They are included in the figures since they would be transported with those evaluated to hospitals; it is also important to observe changes in the number of patients the judges have committed as the program solidified.

Some of the reasons for the trends found in Tables 3 and 4 could be due to changes in the working of the program. This came about through improved efficiency due to increased experience and additional knowledge of outside resources for referral. Monthly meetings were scheduled to iron out difficulties and relax staff conflict. A psychiatric supervisor was added to the program who met weekly with the residents and dealt mostly with disposition problems. Also, for some time the referring judges were not aware of the Interim Program and had not been receiving the dispositions on patients returned to court. This was clarified in June 1971.

From Table 3, it is shown that there has been definite change in the number of alcoholics sent to the state hospitals with 75.6% committed in December 1970 and 51.9% sent in December 1971—or a decrease of 23.7%. The number of alcoholics committed directly by the judges changed from 53.9% of total patients evaluated in December 1970 to 21.2% in December 1971, or a decrease of 32.7%.

In Table 4, 71% of the psychiatric patients were committed in December 1970 with the same amount committed in December 1971. The number of psychiatric patients the judges committed remained low except for May 1971. It could be assumed from this that the initial decrease occurred the first month the psychiatric residents worked with their special skills in diagnosis (the first time this type of training was used here) sending only those that really needed hospitalization for treatment; once this

**TABLE 5: Referrals Made of Patients Evaluated (Psychiatric and Alcoholic) Interim Program—Dec 1971***

| | | TOTAL |
|---|---|---|
| COMMITTED TO COMMUNITY HOSPITALS | | |
| Provident Hospital, Psychiatric Ward | Psychiatric | 1 |
| RELEASED WITH REFERRAL TO COMMUNITY AGENCIES | | |
| Baltimore City Hospital | Psychiatric | 1 |
| Bon Secours Hospital, | Alcoholic | 1 |
| Mental Health | Alcoholic | 1 |
| Johns Hopkins Hospital, Phipps Clinic | Psychiatric | 2 |
| Provident Hospital | Alcoholic | 1 |
| Alcoholism Services | Alcoholic | 2 |
| Community Mental Health | Alcoholic | 1 |
| Quarterway House | Alcoholic | 1 |
| University Hospital | | |
| Alcoholism Services | Alcoholic | 2 |
| Open Clinic | Psychiatric | 4 |
| Tuerke House | Alcoholic | 1 |
| Alcoholics Anonymous | Alcoholic | 2 |
| Baltimore City | | |
| Alcoholism Center | Alcoholic | 2 |
| Geriatric Evaluation Unit | Geriatric | 1 |
| Inner City Community | | |
| Mental Health | Alcoholic | 1 |
| Carey St | Retarded | 2 |
| | No pathology | 1 |
| William St | Psychiatric | 1 |
| | Alcoholic | 1 |
| | Retarded | 1 |
| North Central Community | Psychiatric | 2 |
| Mental Health | Alcoholic | 1 |
| Private Psychiatric Treatment | Psychiatric | 2 |
| | Alcoholic | 1 |
| Veterans Administration | | |
| OPD Clinic | Psychiatric | 1 |
| Drug Program | Drug User | 1 |
| | | **37** |
| RELEASED WITHOUT REFERRAL | Psychiatric | 9 |
| | Alcoholic | 8 |
| REFERRED BACK TO COURT WITH COMMENTS AND REFERRAL SUGGESTIONS | | **17** |
| Medical Services, Supreme Bench | Psychiatric | 1 |
| Provident Community Mental Health | Psychiatric | 2 |
| University Hospital Open Clinic | Psychiatric | 1 |
| Alcoholics Anonymous | Alcoholic | 2 |
| Johns Hopkins Hospital Alcoholism Services | Alcoholic | 1 |
| Baltimore City Alcoholism Center | Alcoholic | 3 |
| University Hospital Alcoholism Services | Alcoholic | 1 |
| Maximum Security Hospital | Alcoholic | 2 |
| | | **13** |
| REFERRED BACK TO COURT WITHOUT COMMENTS AND REFERRALS | Psychiatric | 3 |
| | Alcoholics | 3 |
| | Retarded | 1 |
| | No Pathology | 5 |
| | | **12** |
| | **GRAND TOTAL** | **179** |

* Courtesy of State of Maryland Dept of Mental Hygiene and A Narciso

expertise was used, the numbers committed remained constant in the ensuing months. The major decrease in patients committed has been the number of alcoholics sent to hospitals. This could be explained by the increased knowledge. of community resources available and the skill of the team in getting these facilities to accept these patients.

Table 5 will give an idea of agencies to which patients were referred in December 1971 who were judged not committable.

As noted, 17 were released and not referred and an additional 12 were sent back to court without referrals. This included patients without pathology, and those without motivation or revolving door alcoholics who had not benefitted from numerous hospital visits or community agencies. It should be added that as often as possible in the time allowed, the interviewing team would contact these agencies for specific appointment times since patients were found to follow through more often when this occurred. Finally, the fact that the number of court-committed alcoholics had decreased so sharply can be interpreted by the increased knowledge and confidence which the judges developed in the program to allow the residents to make the evaluation instead of themselves.

## Summary, Discussion

An Interim Program was developed in Baltimore City to help the mentally ill who were charged by the police and sent to local precincts by the court judges to be evaluated by psychiatrists. It replaced a situation in which semi-retired general practitioners evaluated patients without the benefit of psychiatric training or an evaluation team. The Interim Program was only supposed to function for several months until a permanent screening and evaluation until could be operating.

From the figures available the most obvious results were that the total number of females (including alcoholic and psychiatric) committed to state hospitals diminished by 43.6% from 746 in 1969 (old program) to 414 in 1971 (Interim Program) with the assumption that this was true of the male population also. Once the program was running smoothly, the number of psychiatric patients committed to hospitals remained constant at 71% while the number of alcoholics committed decreased by 23.7%. The total number of alcoholics court-committed by judges decreased from 53.9% in December 1970 to 21.2% in December 1971, or a total decrease of 32.7%.

## Comments

These results lend support for the formation of the Interim Program even though it has functioned within jail facilities. The type of evaluation which can be done in such a place is limited not only in the short time allowed but also the negative effect such a facility has upon a mentally ill patient. Hopefully, this type of program can soon be transferred to a permanent screening and evaluation unit where it should prove to be even more effective.




**A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, 5th edition, by George A Ulett, MD, The CV Mosby Co, St Louis, 1972.**

This book presents the facts about mental illness and serves as an introduction to this complex field for the beginning medical student, nurse or mental health worker. With the even greater numbers of persons becoming involved in the treatment and rehabilitation of the mentally ill, this assists them to fulfill their responsibilities in this regard.

**MEDICINE IN A CHANGING SOCIETY, by Lawrence Corey, MD, Steven E Saltman, MD, and Michael F Epstein, MD, The CV Mosby Co, St Louis, 1972.**

This book is based on presentations made in the new course now under way at the University of Michigan School of Medicine. Its contents have the following basic aims: 1) to provide more knowledge about how health services are and are not being provided in society, 2) to make possible an in-depth understanding of the problems inherent in the present method of delivery of health care, 3) to develop insights into how current developments in society are affecting the delivery of health services, and 4) to stimulate thinking on selected proposals that hold the promise of more effectively relating the medical profession to a changing society.

Whether or not you agree with the premises contained in this book and, indeed, whether or not you agree with the objectives is something each person must decide individually.

# CARCINOMA IN SITU OF CERVIX REVISITED

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The purpose of this study was to evaluate our technique of diagnostic work-up, to assess the necessity for different tests, and to estimate the overall results of treatment of patients with early cervical carcinoma.

There were 161 cases considered and diagnosed between Jan 1, 1956 and Dec 31, 1970, an interval of 15 years. One hundred cases were treated before Jan 1, 1966, so that they were followed for at least five years. Not all tests and informations were available for all patients so that the total number of patients presented in subsequent tables may be different.

The mean age of 161 patients was 39 years. There was only one patient in the second decade; the great majority of them (80%) were in the third, fourth, and fifth decade; a considerable number were much older, even over 70 years of age (Table 1). These patients were on the average almost ten years younger than those with invasive carcinoma of the cervix (Table 2).

**Table I: Age of Patients with Ca in Situ***

| | No. | % |
|---|---|---|
| 11 - 20 | 1 | 0.7 |
| 21 - 30 | 38 | 23.6 |
| 31 - 40 | 60 | 37.3 |
| 41 - 50 | 30 | 18.6 |
| 51 - 60 | 18 | 11.2 |
| 61 - 70 | 11 | 6.8 |
| 71 - 80 | 3 | 1.8 |
| **Total** | **161** | **100.0** |

* Mean Age 39

**Table 2: Mean Age in Carcinoma of Cervix**

| STAGE | AGE | |
|---|---|---|
| O | 39.0 | |
| I | 41.6 | 47.6 |
| II | 49.3 | |
| III | 49.9 | |
| IV | 52.0 | |

Almost all patients had been pregnant; only three were known to be nulligravidae (Table 3).

About one half of these women were asymptomatic and were diagnosed to have carcinoma on routine checkup. Another 40% had non-specific symptoms. Only 10.9% of patients had complaints that are considered related to cervical malignancy, mainly postcoital or postmenopausal bleeding (Table 4). This indicated once more the necessity for periodic screening of asymptomatic women in order to increase the diagnosis of early malignancy.

**Table 3: Parity in Patients with Ca in Situ**

| | No. | % |
|---|---|---|
| Nulligravida | 3 | 1.9 |
| Abortions only | 4 | 2.6 |
| Para 1 | 24 | 15.6 |
| Para 2 | 22 | 14.2 |
| Para 3-5 | 52 | 33.5 |
| Para 6 or over | 50 | 32.2 |
| **Total** | **155** | **100.0** |

**Table 4: Symptoms**

| | No. | % | |
|---|---|---|---|
| Routine Check Up | 76 | 48.7 | 89.1% |
| Irregular Menses | 24 | 15.4 | |
| Discharges | 27 | 17.3 | |
| Abdominal Pains | 12 | 7.7 | |
| Postcoital Bleeding | 10 | 6.4 | 10.9% |
| Postmenopausal Bleeding | 7 | 4.5 | |
| **Total** | **156** | **100.0** | |

Description of the cervix was available in only 124 patients: in 36% the portio was described as "normal," over one half showed an "erosion," and the remaining had a variety of nonindicative lesions (Table 5).

**Table 5: Gross Findings in Cervix**

| | No. | % |
|---|---|---|
| Normal | 45 | 36.3 |
| Hypertrophic | 5 | 4.0 |
| Erosion | 71 | 57.3 |
| Condyloma | 1 | .8 |
| Polyps | 1 | .8 |
| Leukoplakia | 1 | .8 |
| **Total** | **124** | **100.0** |

Cervico-vaginal smears were obtained in 125 patients prior to tissue diagnosis of carcinoma in situ. Cytological diagnosis was negative in

four patients, or 3.2%; dyskaryotic cells in 60 patients, or 48.0%; and malignant cells in 61 patients, or 48.8%.

This test, while excellent for screening patients with abnormal cells, does not seem to be very accurate in diagnosing the extent of the neoplastic process.

**Table 6: Biopsy Diagnosis of Dysplasia**

| BIOPSY | | COLD CONIZATION | |
|---|---|---|---|
| | | No. | % |
| Dysplasia 76 | Ca in Situ | 61 | 80.3 |
| | Microinvasive | 12 | 15.8 |
| | Invasive | 3 | 3.9 |
| | **Total** | **76** | **100.0** |

Seventy-six patients had a cervical biopsy indicating the presence of dysplasia (Table 6). Of these, 49 had severe, 12 moderate, and 15 minimal dysplasia. Cold conization of patients with severe dysplasia revealed that 77.7% had in situ, 18.3% microinvasive, and 4% frankly invasive carcinoma. The cone biopsy in patients with moderate dysplasia proved the diagnosis of in situ in 83.4%, microinvasive in 8.3%, and frankly invasive carcinoma in 8.3%. When mild dysplasia was present in the cervical biopsy, the cold conization carcinoma in situ in 86.7% and microinvasive carinoma in 13.3%. No invasive carcinoma was found in the last group.

These findings confirm our former notion that a biopsy diagnosis of dysplasia requires immediate cold conization[1]

**Table 7: Biopsy Diagnosis of Carcinoma in Situ**

| BIOPSY | | COLD CONIZATION | |
|---|---|---|---|
| | | No. | % |
| Ca in Situ 100 | No residual | 20 | 20 |
| | Ca in Situ | 62 | 62 |
| | Microinvasive Ca | 15 | 15 |
| | Invasive Ca | 3 | 3 |
| **Total** | | **100** | **100** |

Cervical biopsy (mostly done with punch forceps) showed carcinoma in situ in 100 patients (Table 7). Immediate cold conization confirmed the diagnosis in 60%. Microinvasive carcinoma was found in 15% and frankly invasive in 3%, while no malignancy could be found in 20% of patients.

After a biopsy diagnosis of carcinoma in situ in 100 patients, the conization revealed that in three of them there was frankly invasive carcinoma. Had this additional diagnostic procedure not been done, these patients would have been subjected to a simple hysterectomy. In the literature, the survival of patients with carcinoma of the cervix who had a hysterectomy in the presence of unsuspected cancer or as the intended treatment of known cervical cancer has been uniformly poor. But these were all cases of advanced cancer.[2-5] Durrance[6] has reported good survival in patients irradiated after simply hysterectomy for early invasive carcinoma. Because invasive carcinoma requiring a different therapy is found only in few cases, and because the prognosis in those cases is equally good, it appears that cold conization may be superfluous after a biopsy diagnosis of intraepithelial carcinoma in absence of a grossly malignant lesion.

Of 161 patients with diagnosis of carcinoma in situ by biopsy and/or cold conization, 158 were subsequently treated, most of them surgically. Irradiation was reserved for a few patients considered poor surgical risks. Combined irradiation and surgery was done in three patients in the earlier years of this study. Two patients refused treatment, and no treatment was advised in one case because of poor general conditions and advanced age (Table 8).

**Table 8: Results of Treatment**

| | | | RECURRENCE | |
|---|---|---|---|---|
| | Refused Treatment | 2 | | |
| | Treatment not Advised | 1 | 1 | 15 mos |
| Surgery | Stumpectomy | 4 | | |
| | Abdominal Hyst. | 115 | 1 | 15 mos |
| | Vaginal Hyst. | 21 | | |
| | Abdominal-Vag. Hyst. | 2 | | |
| | Radical | 4 | | |
| | | 146 | | |
| | Irradiation | 9 | | |
| | Radium & Surgery | 3 | | |

Surgical treatment consisted in total hysterectomy (abdominal or vaginal), with preservation of the adnexa in most cases, and removal of the upper part of the vagina. No fistula formation, other serious incapacitating complications, or death was found following this treatment.

Only one patient developed recurrent carcinoma in situ in the vaginal cuff 15 months after surgery. Another patient not treated had recurrent intraepithelial malignancy 15 months later. Both patients were subsequently treated with irradiation and are alive and free of cancer.

One hundred forty-six specimens were available for histological study and all had had previous conization:

58% showed no residual abnormality
9% only dysplasia
31.5% residual carcinoma in situ
1.5% microinvasive carcinoma

No frankly invasive carcinoma was found. This confirms the effectiveness of cold conization as diagnostic procedure and proves once more the inadequacy of cold conization to eradicate carcinoma in situ.[7,8] In only two patients was intraepithelial carcinoma found in the vaginal cuff.

An attempt has been made to correlate the cytological findings after conization in the surgical specimen. Only 56 of 133 patients were suitable for this analysis (Table 9).

**Table 9: Post-Conization Smears**

| | |
|---|---|
| Negative | 37 |
| Dyskaryotic Cells | 10 |
| Positive | 9 |
| **Total** | **56** |

Thirty-seven smears were negative. After hysterectomy 29 patients were found to have no residual tumor, four dysplasia only, and four (11%) residual carcinoma in situ (Table 10).

**Table 10: Correlation Between Post-Conization Smear and Surgical Specimen**

| SMEAR | | UTERUS | |
|---|---|---|---|
| | | No. | % |
| Negative 37 | No residual | 29 | 78 |
| | Dysplasia | 4 | 11 |
| | Ca in Situ | 4 | 11 |
| **Total** | | **37** | **100** |

Ten smears revealed dyskaryotic cells: four had no residual lesion, five dysplasia, and one (10%) carcinoma in situ in the hysterectomy specimen (Table 11).

**Table 11: Correlation Between Post-Conization Smear and Surgical Specimen**

| SMEAR | | UTERUS | |
|---|---|---|---|
| | | No. | % |
| Dyskarotic Cells 10 | No residual | 4 | 40 |
| | Dysplasia | 5 | 50 |
| | Ca in Situ | 1 | 10 |
| **Total** | | **10** | **100** |

Nine smears were positive for malignant cells: of these, one had no residual abnormality and eight carcinoma in situ in the cervix (Table 12).

**Table 12: Correlation Between Post-Conization Smear and Surgical Specimen**

| SMEAR | | UTERUS | |
|---|---|---|---|
| | | No. | % |
| Positive 9 | No residual | 1 | 11 |
| | Dysplasia | — | |
| | Ca in Situ | 8 | 89 |
| **Total** | | **9** | **100** |

It is difficult to draw conclusions from these small numbers. but from these data it appears that the postconization smear is not an adequate test to separate patients with residual from those without residual malignancy. Others[9] have attempted the study of cervical cones for the same purpose, but the results were also inconclusive.

Only 100 patients were at risk for five years or longer after treatment. Of these, 16 were lost to follow-up; four died of intercurrent disease; 79 were alive and free of disease; and one, who developed a recurrence and was treated with irradiation, is also alive and free of disease.

## Conclusions

Carcinoma in situ of the cervix may be found at any time in a woman's life after puberty. The mean age of patients in this study was about ten years lower than that of patients with invasive cervical carcinoma. Most patients had been pregnant. Only a small minority of patients had symptoms or suspicious findings at time of diagnosis.

Cervico-vaginal smears were a good screening tool, but tissue diagnosis was mandatory to define the extent of the lesion. Punch biopsy of the cervix was not very satisfactory for this purpose, but it is adequate to diagnose invasive carcinoma if the specimen removed shows this lesion. If dysplasia is diagnosed by punch biopsy, a cold conization is mandatory. With this procedure, a more definite diagnosis can be made. No invasive carcinoma was missed by conization. If the punch biopsy shows carcinoma in situ and grossly malignant tumor is not seen or palpated, the necessity for knife conization is disputable.

Residual carcinoma was found in the uterus in about one third of the patients following cone biopsy. Knife conization is, therefore, not considered adequate treatment for carcinoma in situ. At present, there is no reliable method to separate patients with and without residual malignancy after the cone. Simple hysterectomy (or cervicectomy) with removal of the upper vagina appears to be adequate treatment for carcinoma in situ.

No serious complications followed this operation. Of 146 patients treated surgically, only one had a recurrence of in situ carcinoma a short time later. No invasive carcinoma of the genital area has been found. These patients should, nevertheless, be followed periodically for the rest of their lives with pelvic examinations and vaginal smears.

### Summary

One hundred and fifty-six cases of carcinoma in situ of the uterine cervix were analyzed. This disease can be found at any age. In most cases it was asymptomatic and no typical lesion was seen on inspection. Smears are helpful to screen patients, but only a good biopsy can assess the extent of cervical abnormality. Cold knife conization is an excellent diagnostic tool, but cannot be considered adequate for treatment. Simple hysterectomy with removal of the vaginal fornices offers adequate therapy.

To date, there is no method to distinguish between patients who had the whole malignancy removed by cone from those who had part of the neoplastic process left behind. There was only one case of recurrent intraepithelial cancer in 100 cases treated and followed over five years. These patients should be treated either by irradiation or partial vaginectomy. Even after hysterectomy, patients should be followed periodically with smears and examinations for the remainder of their life.

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## MEDICALL NOW IN OPERATION

The first nationwide physicians' information service is now in operation. The idea for the service, MediCall, was conceived by John G Bellows, MD, a Chicago opthalmologist and secretary of the American Society of Contemporary Medicine and Surgery (ASCMS), which sponsors it. It is patterned after the MIST (Medical Information Service via Telephone) program of Margaret Klapper MD, which serves Alabama physicians.

Service is provided on a 24-hour basis to all doctors in the continental United States who seek information from an experienced specialist in a particular field. MediCall has obtained the services of 80 of these specialists. A doctor seeking information may place a call to the MediCall headquarters in Chicago. Specially trained telephone operators then put him in touch with one of the specialists within a matter of minutes.

The nationwide physicians' telephone information service may particularly benefit doctors in remote geographical areas who might not otherwise be able to discuss the most recent advances in medicine, surgery, and other specialties with such highly qualified specialists.

MediCall is currently supported by the American Society of Contemporary Medicine and Surgery. It is hoped that the service will be successful enough to become self-sustaining. The physician seeking information will pay for his telephone call. There may be a fee of $5 to $10 for the information obtained. A portion of that fee will go to the specialist and a portion to the ASCMS. Many of the specialists have volunteered their services gratis.

Only physicians may utilize the MediCall service. It is not open to the general public. Those physicians interested in discussing a particular medical emergency or problem with a specialist may call 312-782-7888.

General information regarding MediCall may be obtained by writing to John G Bellows, MD, 30 N Michigan Ave, Room 1600, Chicago, Ill 60602.

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Nearly one in every four victims in big-game hunting accidents was wrongly identified as an animal by a fellow-hunter; another 13% were wounded because the hunter shot indiscriminately at anything that moved, reports the National Society for the Prevention of Blindness. Each year during the hunting season the National Society receives many reports of such accidents in which hunters are blinded.

# Skin Manifestations of Internal Malignant Tumors

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*This paper, the William Royal Stokes Memorial Lecture, was delivered at the 174th Annual Med-Chi Meeting in Baltimore, May 5, 1972. Information and reprint requests to Dr Curth at 35 E 84th St, New York, NY 10028.*

I would like to confine myself to the discussion of **benign** dermatoses associated with malignant internal tumors. This subject has fascinated me for a long time. Its recognition began with Hebra, who in 1868 observed generalized pigmentation of the skin in a patient suffering from carcinoma. It then received a great uplift with the discovery of the almost classic relations of acanthosis nigricans to internal carcinoma. Gradually, more and more syndromes of dermatoses and malignant internal tumors have become known. Occasionally, the enthusiasm of having discovered yet another such syndrome has made the author forget that some associations of benign dermatoses and malignant internal tumors may occur by chance.

Certain postulates have to be fulfilled if the association of benign dermatoses with malignant internal tumors can be considered causal.

I shall enumerate the postulates and match them with syndromes. Some syndromes are fulfilling only a few, others several postulates.

**1st: The dermatises and malignant internal disease start at the same time or there is only a short interval between the onset of each.**

**Dermatomyositis** is characterized by bluish, reddish discoloration around the eyes and part of the entire face, neck, chest, and extremities. There is erythema of the nail folds. The shoulder girdle, arms, neck, and sometimes the esophagus show muscular weakness.

Usually, dermatomyositis precedes the cancer but the cancer may actually have been present although not recognized.

Statistics for the association of dermatomyositis with cancer are meaningful only if they are restricted to adults with the dermatosis, since cancer does not occur in children with dermatomyositis. The percentage of adult patients with dermatomyositis and cancer varies in the various statistics from 13% to 36%. In one statistic that deals with patients over 40, the percentage of patients having dermatomyositis and cancer is 52%.

No difference between the clinical aspect of dermatomyositis with or without cancer can be recognized.

The dermatosis regresses after the elimination of the tumor but does not always exacerbate following renewed activity of the tumor.

Patients with dermatomyositis show skin hypersensitivity to extracts of their own tumors. This, however, does not mean dermatomyositis can be explained as a phenomenon of autosensitization, because certain tumors show circulating antibodies and this often in the absence of dermatomyositis.

**Acquired ichthyosis** shows generalized dry and cracking skin and alopecia, and histologically dermal and epidermal atrophy. The patients are suffering from Hodgkin's disease, reticulolymphosarcoma, aplastic anemia, mycosis fungoides, multiple myeloma, and also cancers; as you see, a high percentage concerns reticuloendothelioses. Sarcomatous tumors or malignant internal disease may precede the cutaneous signs.

**2d: The internal malignant process and the dermatosis (unless self-limited as for instance herpes zoster) run a parallel course.**

**Malignant acanthosis nigricans,** chosen to illustrate this principle, could, by the way, be chosen for almost all criteria. It fulfills almost all of them.

The axillas (Fig 1) and most of the other body folds show hyperpigmented, verrucous, elevated, and confluent skin changes. The nipples and umbilicus are hyperkeratotic and hyperpigmented. The mucous membranes show papillomatous, nonpigmented changes. There may be keratoses of the palms and soles.

The parallel course of the two disorders, cancer and malignant acanthosis nigricans, is so closely observed that I could pick up an adenocarcinoma of the sigmoid colon because of slightly increased papillomatosis of the lips.

This black man had slightly progressive malignant acanthosis nigricans. At that time he was 81 years old. A gastric lyomyoma, a squamous



Fig 1: Left axilla of 63-year-old woman with gastric cancer.

cell cancer of the bladder, and a transitional cell carcinoma of one kidney were successively removed. Since the cutaneous lesion did not disappear following these operations, search for the associated tumor continued. Besides, none of these tumors were adenocarcinomas, which I had by that time recognized as the causually related tumor of malignant acanthosis nigricans. Later, but before the patient had any symptoms or signs of an internal carcinoma, he showed mild spreading of oral papillomatous lesions. A barium enema disclosed an adenocarcinoma of the sigmoid colon. It was removed. Six and a half years later he died at the age of 90 of heart failure. Malignant acanthosis nigricans had completely disappeared after the last operation. This case, by the way, also proves that the cancer of malignant acanthosis nigricans, if discovered in time, is not always so hopeless as was believed before.

There is another case of survival of malignant acanthosis nigricans with a cancer of the sigmoid colon on record.

If one believes that some component of the cancer exerts an effect on the skin this must mean that, in cases in which the dermatasis precedes the cancer by many years, the cancer has been active in some form. In malignant acanthosis nigricans the dermatosis may precede the cancer by up to 16 years. From a certain moment on, however, the two manifestations will develop in a parallel way.

Malignant acanthosis nigricans is only one of four types of acanthosis nigricans but I can only briefly tell you what the three other types signify. The different types resemble each other and only an analysis of the important factors such as age at onset, family history, presence or absence of obesity (Fig 2), will determine with which type one is dealing. If an adenocarcinoma is present, a diagnosis of malignant acanthosis nigricans is not difficult to make, but one must have the courage to diagnose malignant acanthosis nigricans even in those cases in which no cancer seems to be present.



Fig 2: Pseudo acanthosis nigricans in 14-year-old obese Italian girl.

It is unjustified to consider a case as one of benign acanthosis nigricans if in a nonobese adult acanthosis nigricans begins and no cancer is found. One may have to wait for many years after the onset of the dermatosis for the manifestation of the cancer.

**3d: The type of the neoplasm associated with the dermatosis may be uniform or distinctive, ie, its mechanical, toxic, or biochemical action has specific effects on the skin.**

For the illustration of such a tumor, I have

chosen acquired **pachydermoperiostosis** associated with a lung tumor.

The skin of the face, chiefly of the forehead, is thickened and shiny and new folds are created. On the scalp, there is cutis verticis gyrata. The lids, lips, and ears are thickened.

The extremities are enlarged, the fingers are clubbed, and the palms are rough. The pathologic changes of pachydermoperiostitis seem to be caused by increased peripheral circulation during the active phase of the disorder.

The tumor is chiefly a bronchogenic cancer in men over 40. Acral changes may precede the manifestation of the pulmonary cancer.

Another distinctive tumor is the **functioning carcinoid,** which causes either episodic or permanent flushing, which in turn may lead to persistent telangiectasia or permanent cyanosis. The tumor is either ileal, bronchial, ovarian, gastric, appendical, rectal, or other. Not every carcinoid leads to the cutaneous changes. Serotonin, 5-hydroxytriptamine is chiefly destroyed in the liver but in the presence of hepatic metastases it is produced there and escapes inactivation in this organ. Serotonin is at least partially responsible for the flushing.

With regard to the uniformity of the tumor, dermatomyositis, which we discussed before, does not fulfill this criterion. The tumors are not uniform, some are squamous celled, some are adenocarcinomas. Interestingly, some tumors are bilateral, ie, tumors of both breasts or both ovaries occur. The tumors of malignant acanthosis nigricans, however, are all adenocarcinomas.

**4th: The dermatosis is not common.**

Acanthosis nigricans proves this. For the illustration of another uncommon dermatosis, I have chosen **erythema gyratum repens.** We find a bizarre, zebra-like patterned skin. The tumor is a bronchial, mammary, cervical carcinoma, or a squamous-celled cancer of the tongue. The tumor appears first and there is an immediate clearing of the skin after the treatment of the tumor.

**Acquired lanugo hair,** another bizarre dermatosis, has only lately been recognized. It is observed in association with various internal cancers of the bladder, lung, or gall bladder, respectively. The excessive hair growth (malignant down) occurs over the face and entire body and may reach, on pubic and axillary regions, 3-15 cms in weeks. At the same time the internal tumor becomes evident. It is believed that there is a prolongation of the anagen stage with synchronization of all hair follicles. No endocrine disturbance seems to be present.

The generalized form of **reticulohistiocytoma** shows firm, pinkish nodules over joints, dorsa of hands, scalp, face, ears, trunk, and mucosa of lips, and affects the joints with destructive polyarthritis. There is an elevation of the total serum lipids. The fingers look shortened such as opera-glass hands. The dermatosis is associated with internal sarcomas and adenocarcinomas.

Since uncomplicated dermatitis herpetiformis is a disease of young people and responds to treatment with sulfapyridine or sulfones **dermatitis herpetiformis** in middle or old age, not responding to this treatment may be a different entity. It may be associated with several kinds of cancer. There is a parallelism of the course of the two manifestations; but, when cancer reappears, the dermatosis does not always recur, perhaps because the recurring cancer is not necrotic as the first one was. **Bullous Pemphigoid** resembling pemphigus vulgaris, and also occurring in the oral cavity, can, in a small number of cases, be associated with all kinds of tumors. The presence of antibodies to the basement membrane in the sera of patients with bullous pemphigoid has been firmly established by direct and indirect immunofluorescent methods.

**Herpes zoster**—In a high percentage herpes zoster occurs in the same segment as the tumor (Fig 3). Most tumors have been irradiated four to 40 months prior to the onset of the dermatosis. Contrary to expectations the prognosis is not too bad. Generalized herpes zoster occurs in a high percentage with various tumors or reticuloendothelioses.



Fig 3: Herpes zoster of left side of back in 51-year-old woman appearing 45 and 29 months, respectively, following left mastectomy and ten to 12 months after radiation therapy.

Another dermatosis that may appear after radiation of an internal tumor is **erythema multiforme.** It begins one to 21 days after the radiation. This dermatosis also occurs in the presence of nonirradiated internal tumors of various kinds and is regarded as an ominous sign.

An **annular erythema combined with superficial necrosis** of the skin seems pathognomonic of a pancreatic islet-cell carcinoma.

One has to take the limitations concerning uncommon dermatoses with a grain of salt since pruritus or urticaria, certainly common disorders, may be preceding or accompanying leukemia or cancers. Freckles and seborrheic keratoses are common and usually do not denote any malignant internal tumor but may, on the other hand, be the forerunners of malignant acanthosis nigricans and thus may eventually be associated with cancer.

**5th: If the association between dermatosis and malignant disease is based on a genetic relationship the internal disorder and the dermatosis develop independently of each other and postulates 1 and 2 will not be fulfilled.**

Example: **Gardner's syndrome** is present at birth and childhood and shows multiple soft tumors, osteomas, and polyposis of the large intestines with subsequent development of carcinoma of the lower digestive tract. The incidence of malignant alteration is 45% to 53% and resembles that of multiple familial polyposis. It calls for strong preventive measures; colectomy in early adult life seems justified. Most probably the disorder is caused by an autosomal pleiotropic dominant gene and was once observed in five successive generations.

Another syndrome based on a genetic relationship deals with **palmar and plantar keratoses and esophageal carcinoma.** It has been observed in two Liverpool families. The keratosis begins at puberty, and the cancer in later life.

A few words are in order about cancer in the **Peutz-Jeghers syndrome,** a disease of pigmented spots of the lips and fingers with polyps in the small intestines. There are several cases with documented transition of benign polyps to adenocarcinomas even in the small intestines, which in general do not lend themselves to malignant degeneration. Prophylactic excision of polyps is not justified. Cancers also develop in polyps arising in the stomach, duodenum, colon, or rectum. These polyps may accompany the typical polyps in the small intestines.

There is another **distinctive-appearing ovarian sex cord tumor** occurring in women with the **Peutz-Jeghers syndrome.**

**6th: The incidence of association between dermatosis and malignant internal disease is statistically important. Such a syndrome will, if one searches further, either fulfill the first four criteria or show a genetic background, as postulated in #5.**

Dermatoses, with a statistically important association with malignant internal tumors, which is based on a genetic relationship, are difficult to determine because the time of onset of the two disorders is not the same in the two manifestations. I have been impressed by the association of **unilateral nevi** and malignant internal tumors in adult life.

A patient of mine had benign acanthosis nigricans and a unilateral epidermal nevus on the right side of the abdomen. It was histologically indistinguishable from benign acanthosis nigricans. The axillas showed signs of acanthosis nigricans only around puberty. In his 30s he developed a mucoepidermoid cancer of the left parotid gland. This, mind you, was not an adenocarcinoma nor did the unilateral nevus or some previous signs of acanthosis nigricans become activated. He still has benign acanthosis nigricans. There are additional reports of associations of unilateral nevi and malignant internal disease.

Let me say a few words about **palmar keratoses and cancer.** A short while ago Dobson et al reported that cancerous patients have four to five times as many palmar and plantar small keratoses as individuals without cancer. It is always risky to point to a feature also present in normal individuals but in a smaller percentage. Actually, an increased presence of palmar keratoses in cancerous patients could not be confirmed by my examining 41 patients with cancer at the Delafield Hospital, New York.

Bean et al found a greater incidence of palmar keratoses in the controls than in the cancer patients. Gilbertsen et al followed up patients with and without keratoses for three years for visceral cancer. Both groups showed developing cancer in the same percentage. It may be exposure to arsenic that is responsible for the keratoses.

To summarize, I refer you to Tables 1 and 2 which consider the associations just discussed from different points of view: these tables show which dermatoses are and which are not always associated with malignant internal disease.

Table 3 shows which relationships permit some explanation of the principles involved in these syndromes. But the mechanisms operating in the majority of syndromes are still unknown. You see that a great deal of work has still to be done.

**Table 1: Dermatoses in which the causal relationship between cutaneous manifestations and malignant internal disease is well established. In some dermatoses the association with malignant disease occurs in all, in others in many instances of the dermatosis.**

1) Malignant acanthosis nigricans
2) Dermatomyositis of the adult
3) Flushing (with carcinoid)
4) Acquired pachydermoperiostosis
5) Acquired ichthyosis
6) Malignant down
7) Palmar & plantar keratoses
   (with esophageal cancer)
8) Erythema gyratum repens
9) Reticulohistiocytoma

**Table 2: The association with a malignant internal disease does not occur in all or many instances of**

a) Pruritus
b) Urticaria
c) Dermatitis herpetiformis and pemphigoid
d) Erythema annulare centrifugum
e) Erythema multiforme
f) Scleroderma
g) Herpes zoster
h) Freckles and seborrheic keratoses
i) Unilateral epidermal nevi
j) Hyperpigmentation and Cushing's syndrome
k) The Peutz-Jeghers-Touraine syndrome
l) Gardner's syndrome

**Table 3: Principles Involved in These Syndromes**

1) A special tumorous activity causes the dermatosis
   (Example: flushing due to carcinoid)
2) Special tumors are associated with special dermatoses
   (Examples: lung tumors cause pachydermoperiostosis
   adenocarcinomas cause acanthosis nigricans
   reticuloenodothelioses cause ichthyosis
   a necrotic tumor may be associated with dermatitis herpetiformis)
3) A genetic relationship exists between dermatosis and malignant internal tumor
   (Example: Gardner's syndrome)
4) A benign tumor associated with a dermatosis undergoes malignant degeneration
   (Example: Peutz-Jeghers syndrome)
5) Deep irradiation of the tumor causes the dermatosis
   (Examples: erythema multiforme
   herpes zoster)

**References**

A complete listing of the 24 references used with this article may be secured from the author.

## Cure for the Common Cold?

A few months ago, the big toe became news in medical circles. What made it an anatomical celebrity was the fact that two Israeli researchers reported that they had found a cure for the common cold by chilling big toes with a refrigerant chemical. According to the doctors, the sudden chilling dried up nostrils and "cured" the cold. Cold remedies through the ages have tended to the offbeat side, from wearing a garlic clove around the neck to taking massive doses of vitamin C.

The debate about the efficacy of such remedies rages on—and so does the common cold. And while such is the case, the sufferer is best advised to stick to such tried and true precautions as: 1) more bed rest than usual; 2) a hot tub or shower before bed time to help decongest respiratory passages; 3) judicious use of aspirin and nasal decongestants to relieve symptoms; 4) lots of fluids. If your temperature rises above 101 degrees or if a shaking chill, deep cough, or if ear, chest or throat pains develop, it's time to see a doctor.

## Test Sugar as Hiccup Cure

The next time you develop a serious case of hiccups—try swallowing one dry teaspoon of white granulated sugar.

That's the latest hiccup cure remedy being offered by medical science.

The new treatment, according to the Health Insurance Institute, is laboratory tested—and at last count worked in nine out of 20 cases.

The experiments were conducted by Dr Edgar G Engleman, of the University of California, and Drs James and Barbara Lankton of the University of Miami School of Medicine.

The scientists said that three of those "cured" later got the hiccups again, but the sweet treatment relieved them again.

Hiccups are the result of involuntary contractions of the diaphragm muscle which controls breathing.

And while hiccups are usually no more than a short-lived nuisance, when prolonged they can debilitate the body, and even cause death.

So next time, try the sugar treatment, suggests the Institute, it is indeed sweeter than being frightened suddenly, getting a push on the eyeballs, or holding your breath until blue—all old standard remedies.

# Primary Care Nurse Practitioner Program

**SUSAN DILTS**
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*Dr Marion I Murphy, dean of the University of Maryland School of Nursing, recently announced that the School has been awarded a $467,432 contract by DHEW to conduct a three-year Primary Care Nurse Practitioner Program. This article reports on that program.*

*Information and reprint requests to 660 W Redwood St, Baltimore, Md 21201.*

The purpose of the University of Maryland's Primary Care Nurse Practitioner Program is to prepare selected nurses for an expanded role in the delivery of health care, education, and training. It will also provide continuing special programs in primary care for nursing faculty.

Unlike the currently popular "physician's assistant" training programs, the Primary Care Nurse Practitioner Program will prepare nurse practitioners to provide new types of health care. The physician's assistant allows the physician to see more patients by assisting him in some of his duties; however, he is unlicensed and dependent on the physician in the actual delivery of health care. By comparison, the Primary Care Nurse (or Nurse Practitioner) is able to assume increased responsibility in comprehensive health care for individuals and their families, by making more independent judgments and decisions in collaboration with the physician, and with the assistance of newly acquired skills and knowledge. She assumes responsibility for identifying needs, determining their urgency, and taking appropriate action. The emphasis of her practice will be on health maintenance and disease prevention. She will, however, seek consultation and work in close collaboration with the physician and other health professionals who make up the "team."

Breaking away from her traditional role as the doctor's helper (taking temperatures, blood pressures, draping the patient, etc), a graduate of the University of Maryland's Primary Care Nurse Practitioner Program will be expected to fulfill a wide spectrum of responsibilities. She will perform complete medical histories and initial physical examinations, then help formulate a plan of disease prevention and therapy.

Assuming more responsibilities in the varied aspects that make up "comprehensive" health care, the Primary Care Nurse will take part in areas such as well-baby care, family planning, and in establishing and maintaining treatment programs for chronic diseases such as diabetes, asthma, and hypertension through Nurse Clinics. She will make health care more available through home visits, coordination with community services, and follow-up of the patient in the home, clinic, office, or hospital. Part of this follow-up includes establishing and maintaining a lifetime health record for each patient which identifies social, behavorial, and environmental problems as well as physical disease, and stresses ability rather than disability, and prevention and health maintenance rather than just treatment of physical illness. She will be an active participant in the education and training of other nursing students and health personnel. She will help patients move through what is frequently a confusing health care system, by making appointments and referrals to other services, and aiding in the transition in and out of the hospital. Under the leadership of the physician, the Primary Care Nurse will help to coordinate the activities of the other health team members. And, perhaps most importantly of all, she will provide care on a personal, one-to-one basis, in an era when health care has in many cases become impersonal.

Numerous programs across the country are preparing nurses to function in various types of expanded or assisting roles in the delivery of health care. The Primary Care Nurse Practitioner Program at the University of Maryland is unique because it includes an emphasis on "educating the educators." Not only will the Program meet the immediate needs of educating and training registered nurses presently functioning in health centers or doctors' offices, it also meets the long-term needs of educating and training nursing faculty to educate present and future students for new and expanded roles. Graduates of the Program will, therefore, serve as "role models" and teachers for the nurses of the future. At the end of the three years covered by this grant, the Program will have produced its own faculty, and will be completely incorporated into the baccalaureate and masters curricula of the University of Maryland School of Nursing.

Another important emphasis of the Primary Care Nurse Practitioner program is its flexibility; its curriculum will be adjusted to suit individual needs. Nurses selected for the Program will come from a variety of clinical backgrounds, from those with diplomas to masters' degrees, and will return to practice in a physician's office, an out-

patient department, or a community health center. These nurses can be either employer-referred or self-referred; in the case of a physician referring his nurse, he is required to make a commitment for her job when she completes the course. Before a nurse is accepted for the Program, a visit will be made to observe her function in her present surroundings, and to consult with her employer and the physician or physicians for whom she works, in order that her plan for study can be tailored to those aspects of nursing that will best benefit both the nurse and her community.

All students taking the course will participate in a major "core" of study. From this center, each nurse will branch out into the areas most important to her individual job, ie, well-baby care, maternity care, drug education, psychiatry, laboratory work, etc. Toward the end of the course, each referring physician will come to this campus to observe his nurse with patients; and later, when both return to practice in their own "home" setting, they will receive follow-up support by University faculty. The student's concept of her own role is another aspect of the Program directed toward the individual. Before being selected for the course, each student will be interviewed in terms of this role concept; and each individual's study will be planned in response to her own needs, and in response to her role in present and future care systems.

One of the most important features of the Program is its strong commitment to continuing education and follow-up. Once a nurse has completed the course and returned to her practice, she will be evaluated in order to determine what she has gained. In addition, she and physician colleagues will be invited to return to the University for refresher courses in the future.

Based on the belief that optimal health care for large numbers of people is delivered by a **health care team,** the Primary Care Nurse Practitioner Program places great emphasis on coordination between the members of the team: the physician, nurse, pharmacists, social worker, health aide, etc. The University of Maryland is in an ideal position to institute such an approach.

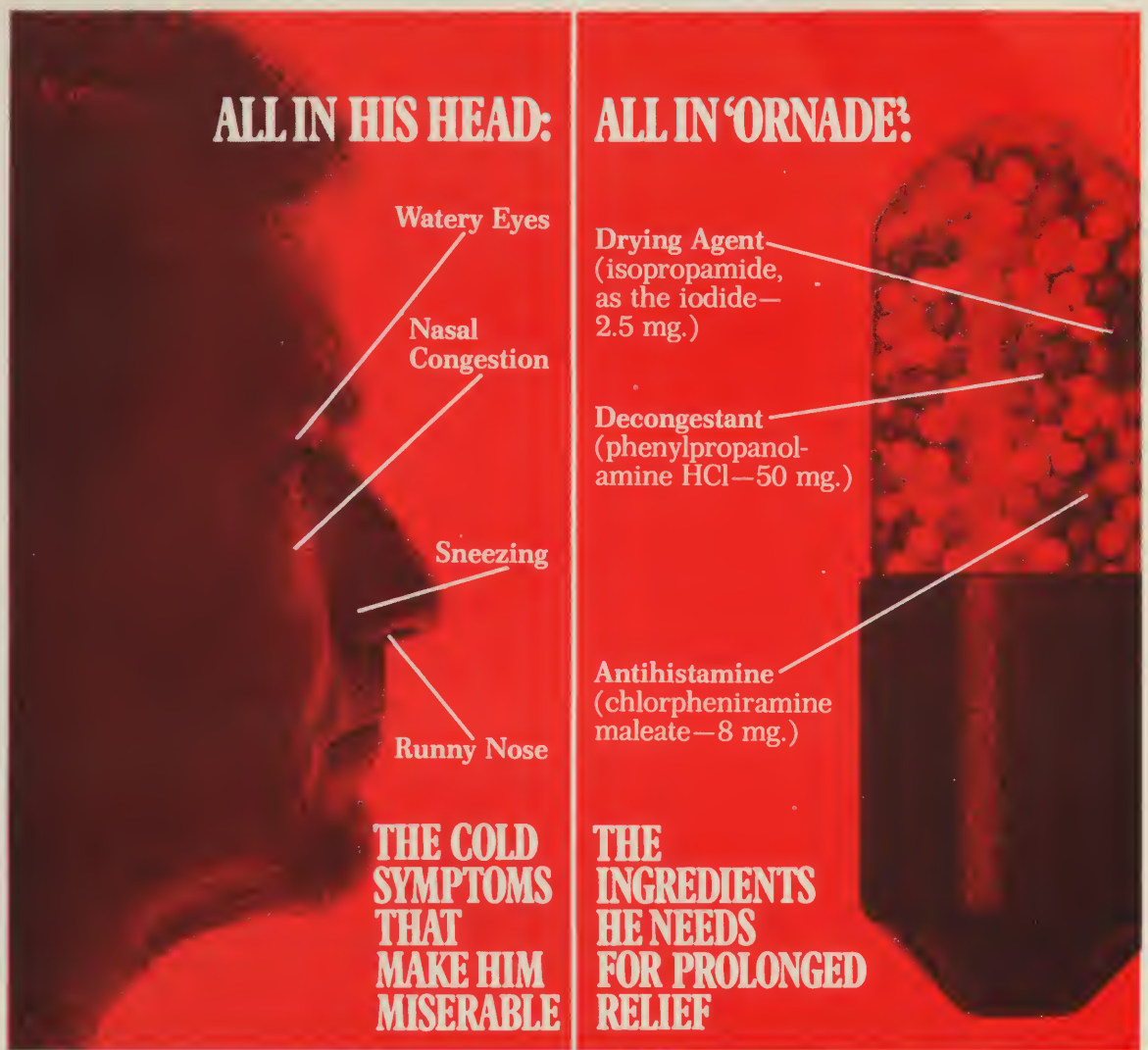
Plans for the Program have been a cooperative effort of the Schools of Nursing, Medicine, and Pharmacy at the University, and began two years ago in response to demands by physicians, nurses, and health centers. During this period, the University has conducted two pilot programs and numerous studies to determine the best methods of carrying out such a program. A six-week pilot training course was conducted during March and April 1971 to find the most effective methods of teaching comprehensive physical diagnosis to a select group of nurses. This was followed by a 36-week course: the Primary Care Nurse Education Program, from September 1971 through May 1972. Twelve students participated in this part-time course: nine full-time RNs working in Ambulatory Services at University Hospital, and three faculty members from the School of Nursing. Graduates of this course will serve as role models and faculty for the three-year Program; and are presently assisting in an evaluation of the pilot program.

Based on the results of these two years of planning and testing, the new Primary Care Nurse Practitioner Program has been established under the directorship of Mrs Rachel Z Booth, associate director of ambulatory nursing, with William S Spicer Jr, associate dean of the University of Maryland School of Medicine serving as a medical codirector. Miss Frances P Koonz, director of continuing education in the School of Nursing, will assist with the Program.

The curriculum for the Program has three major priorities: 1) to train family (or "comprehensive") primary care nurse practitioners; 2) to train nurse practitioners who will be equipped to plan and maintain Nurse Clinics for chronic diseases; and 3) to train nurse practitioners to aid physicians practicing in areas of doctor shortage. To fulfill these objectives, the emphases of the proposed curriculum will be on the nurse's concept of her role; systems teaching, including physical diagnosis, basic science, epidemiology, pharmacotherapy, and problem-oriented histories; seminars in behavioral problems and communication; management concepts; and varied clinical experiences with designated physicians serving as preceptors to each student.

The HEW grant provides for two full-time classes per academic year, each lasting 16 weeks. In addition, there will be a special part-time program for nursing faculty running from September 1972 through May 1973, and repeated the second year. The first full-time course will begin in January 1973.

Clinical facilities will be provided by the University of Maryland Ambulatory Care Clinics, using three types of health care delivery models: a comprehensive care unit, a screening unit, and specialty clinics. The students will divide their time between the classroom (including audiovisual material and laboratory experience), working with patients in the clinics, working with their preceptors, and independent study. Each class is planned for an enrollment of ten to 12 students, who will be chosen by an admissions committee. There will be no tuition charged for the Primary Care Nurse Practitioner Program.




Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

**Indications:** Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

**Contraindications:** Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

**Warnings:** Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

*Usage in Pregnancy:* In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

*Effect on PBI Determination and $I^{131}$ Uptake:* Isopropamide iodide may alter PBI test results and will suppress $I^{131}$ uptake. Substitute thyroid tests unaffected by exogenous iodides.

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**Adverse Reactions:** Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

**Supplied:** Bottles of 50 capsules.

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Each capsule contains 8 mg. of Teldrin®(brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

## UNCOMMON RELIEF FOR COLD SYMPTOMS

# If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen***).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E***).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen***).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as Enovid-E* or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. Has recurrent trichomoniasis and Monilia.
Indicates estrogen deficiency and excess of progestogen in current O.C.
1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E*** or **Ovulen*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.
Indicates probable need for more estrogen.
1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.
Indicates probable progestogen excess.
1st choice: Switch to a center-spectrum pill (such as **Ovulen***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has pre-menstrual fluid retention and leg cramps.
Indicates probable excess of estrogen.
1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen***).



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Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

**Demulen®** a moderately progestogen-dominant O.C. for many
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Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

**Actions** – Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note** – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication** – Ovulen and Demulen are indicated for oral contraception.

**Contraindications** – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings** – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions** – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives** – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in $T^3$ uptake values; metyrapone test and pregnanediol determination.

**References: 1.** Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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**Indication** – Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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***Where "The Pill" Began***

272R

# THE PHYSICIAN'S LEGAL DUTY TO REFER A PATIENT TO A SPECIALIST

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*The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.*

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In a recent medical malpractice case against the United States, a major contention of the plaintiff was that the physician was negligent for not having consulted specialists in the area of the patient's disorder. The claim was settled out of court for a sum in excess of $100,000. For purposes of comparison, consider the facts of a different case in which a similar allegation of negligence has been made.

At two o'clock in the afternoon, a mother carrying her young child entered a busy emergency room of a large hospital. The mother informed the receptionist that her child had swallowed some iron pills. They were escorted to an examining room, and the doctor on duty was summoned. The examining physician, a general practitioner, learned from the mother that the child had ingested an unknown quantity of iron pills. The pills were part of a prescription the mother had been given for treatment of anemia during pregnancy. The interval between the child's ingestion of the pills and the examination of the child in the hospital emergency room was less than two hours. During this interval the child had vomited, but the mother was not certain whether all of the pills had been expelled.

Examination of the child revealed a normal, unimpaired infant in no obvious distress. Although a number of pediatricians were on call and were available in the hospital at the time, the examining physician sent the child home without benefit of consultation. Two hours later the infant was returned to the emergency room in a comatose condition. The child was examined by a pediatrician on the return visit, and the diagnosis of acute iron poisoning was made. Despite institution of appropriate therapy, including deferoxamine, the child survived only a few hours.

Suit was filed alleging negligence on the part of the initial examining physician for not referring the patient to a specialist initially.

The determination of liability in situations involving the duty of a physician to refer a patient to a specialist is not an easy matter. There are no statutes dealing with the problem. To arrive at a determination of liability we must look to the applicable case law.

The general rule governing the duty of a physician to refer a patient to a specialist was established in the case of *Logan v Field.* In this case the court stated that if a physician who is not a specialist in the field of the patient's illness knows or should have known that the patient in his care was not improving and that other treatment would be beneficial and is reasonably available, the physician is negligent if he does not tell the patient such treatment would be advisable.[1]

The rule espoused in the Logan case as well as later interpretations of it require the physician to have and to exercise competent or reasonable skill and to apply that degree of care generally employed by other members of the profession under similar circumstances.

In *Manion v Tweedy* the defendant physician had diffculty in the proper alignment of the patient's fractured leg. Expert testimony for the plaintiff indicated that the problem could have been resolved if the proper specialist had treated the patient. In finding for the defendant physician, the court held that there was no showing that the physician knew that the patient's condition was beyond his knowledge, skill, or ability to treat with a likelihood of reasonable success. The court pointed out that the physician's

experience was extensive and that not every treatment of a patient that turns out to be less than a complete success leads to a claim of negligence based on a failure to refer the patient to a specialist.[2]

In the case of *Sinz v Owens* the defendant physician treated a patient's fractured leg without utilizing the indicated skeletal traction. The result was a malaligned leg. Expert witnesses for the plaintiff testified that at the time of the treatment it was the general custom of physicians practicing in that community to refer cases requiring skeletal traction to a specialist in a town 12 miles away.[3]

In the 1954 case of *Balder v Rogers,* the defendant physician treated the patient's cancer of the lip with injections of glyoxide, after which the patient's condition grew steadily worse. The court held that the physician was liable for failure to arrange other medical attention for his patient or to advise the patient as to the possibility of additional or different treatment such as radium, X-ray or surgery.[4]

If a reasonably careful and skillful physician would have suggested referring the patient to a specialist, a physician who does not do so may be liable for negligence if harm results.[5] Of course, the alleged negligence must be proved by the testimony of expert witnesses, and the charge will not be sustained unless the average physician would have referred the patient under the same or similar conditions.

The physician is not required to be professionally infallible and will not be held liable for an honest error of judgment. Liability arises when it is shown that he knew or should have known that the patient's condition was beyond his ability, knowledge, or capacity to treat.[6] In a suit against the United States in which Georgia law was applied, the court ruled that the Government physicians were negligent in not seeking assistance from available orthopedic surgeons when it became obvious that the patient's fracture was not properly aligned. The physicians were also negligent in failing to inform the patient of the known malalignment. Though the physician's knowledge of the problem was documented in the patient's medical records, these were not made available to the patient.

If the patient's condition is beyond medical science and special treatment is either nonexistent or would be useless, the physician has no duty to refer.[7]

If one applies the principles of the aforementioned cases to the case of the infant death from iron poisoning, the result should be no liability for any claim based on a failure to refer. In order for a physician to be held liable for a failure to refer, he must recognize that other treatment is necessary and is available.[8] Although other treatment was available, the physician in the iron poisoning case did not recognize that other treatment was needed. In his opinion, the child did not require specialized treatment. Therefore, if liability existed in the case, it must be based on a claim of negligent failure to diagnose and not on a claim of negligent failure to refer, at least under existing law.

The problem may be compounded by the fact that the failure to diagnose the iron poisoning occurred at a large hospital where specialists were readily available for consultation. This raises the question of whether a physician is held to a different standard care when practicing in such surroundings. Under existing law there is no absolute requirement that the treating physician consult a specialist in every case. By analyzing trends in medical malpractice litigation, however, we should be forewarned that such a judicially determined standard may not be far away. If such a new requirement should develop, it will apply to all physicians, since even those in the most remote portions of our land are no more than a phone call away from the necessary specialists and latest recommended treatment.

For the present, those physicians most at risk of suit will be the nonspecialists who are required to work in emergency rooms regardless of training, experience, or interest. Their only salvation may be to rely more heavily on those specialists who are on call to provide back-up services in the difficult cases.[9] The time is not too far distant when physicians may no longer be able to escape liability by stating: "I did the best I could." The only acceptable response may well become: "The profession did all it could."

**References**


1. Logan v Field, 75 MO App 594 (1898).
2. Manion v Tweedy, 257 Minn 59, 100 NW 2d 124 (1959).
3. Sinz v Owens, 33 Cal 2d 749, 205 P2d 3 (1959).
4. Baldar v Rogers, 81 So2d 658, 55 ALR 2d 453 (1954 Fla).
5. Benson v Dean, 323 NY52, 133 NE 125 (1921).
6. Manion v Tweedy, 257 Minn 59, 100 NW 2d 124 (1959).
7. Tucker v Stetson, 233 Mass 81, 123 NE 239 (1919).
8. Manion v Tweedy, 257 Minn 59, 100 NW 2d 124 (1959).
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# INDUSTRIAL MEDICINE AND THE LAW

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*This paper, an I. Ridgeway Trimble Fund Lecture, was delivered at the 174th Annual Med-Chi Meeting in Baltimore, May 5, 1972. Information and reprint requests to Dr. Frankel.*

The problem of litigation has affected the practice of medicine in all of its aspects. Physicians associated with industry have not been spared. The individual physician looks to his county society for guidance. The county looks to the state. The state looks to the AMA, and the AMA, like any organization, is, of necessity, reactionary.

The problems of industrial medicine and surgery apparently encompass the problems that affect every individual field in the practice of medicine. In a typical issue of the *International Journal of Industrial Medicine and Surgery* are to be found sophisticated articles on toxicology, orthopedics, physical therapy and rehabilitation, neurosurgery, psychiatry, general surgery, and even research.

Is industrial medicine a specialty? If so, what are the duties and responsibilities of the industrial physician? Is he responsible to his employer? Or is there a doctor-patient relationship set up between physician and employee? Are his responsibilities advisory, or do they include therapeusis? Who makes the rules by which the industrial physicians determines what is to be done with and for a patient? Can the employer insist on the basis of economy that his plant physician handle every and any type of emergency, or illness, or injury; that consultation be limited again for reason of economy?

Are there any guidelines set up by the industrial medicine and surgical groups whereby the organization recommends that people without adequate backgrounds in special fields refer their problems to those who do have acceptable training? Certainly the industrial physician will be subjected to the same standard of care that the practitioner outside the field of industrial medicine is subjected to, but there comes the rub. What is the standard of practice?

By definition developed by lawyers and courts, malpractice is a deviation from the standard of practice which results in damage to the patient. For many years, practitioners were judged by the standards of their community, or of a similar community. Specialists were held to a higher standard than general practitioners. The standard of practice in Catonsville was, therefore, deemed to be much lower than in Baltimore, despite the fact that the practitioners may have graduated from the very same school, were certainly taught in the same fashion, and were expected to pass the same type of examination. A few years ago I was asked to give an opinion about the presence or absence of negligence in a case involving an eight-year-old youngster who sustained a fracture of both bones of his forearm. The general surgeon in a modestly sized Georgia town set the fractures and hospitalized the youngster after applying a circular cast. After several days of complaint of pain and swelling, the cast was partially split, and after a day or two more, new X-rays were taken, and Volkmann's contracture was noted. The child was referred, at that time, to the Mayo Clinic. A suit developed, and it was my opinion that the general surgeon was negligent in not being aware of the complications from the treatment of a fracture of a forearm in which there is marked swelling, that he should have been aware of the presenting symptoms of impending Volkmann's contracture, that consultation was close at hand, about 30 miles away, and that, but for the surgeon's negligence, in all probabilities this child would not have had the irreversible injury to his arm.

The case came to trial, and the lower court said that the expert witness from out of the state was in no way familiar with the standards of practice in that Georgia community; therefore, his testimony was of no use; they held for the defendant. The case was appealed and, in a far reaching decision, the appellate court in Georgia threw out the locale rule. The judge, in a brilliant decision, stated that the locale rule was intended for use in the days when there were few medical schools, when there were few roads, no telephones, and transportation was very difficult. The judge wryly added that he had been reading Hippocrates, and Hippocrates stated that an injured extremity should not be bound too tightly,

lest it cause circulatory damage. The judge added that if that information was available in 500 BC in Greece, that it certainly should have reached Georgia in 1967, and so ended the locale rule in Georgia and in many other states.

The unfortunate victim of the ruling was the general surgeon. I say unfortunate because he got little help from the medical organizations to prepare him for the embarrassing disaster that litigation visits on some defendants. The opinion I expressed was that of a teacher and a practitioner for 35 years. Nowhere are there to be found guidelines for a standard of care in any of the various fields of medicine and surgery. Belatedly, the American College of Anesthesiology has come forward with some guidelines. The American College of Surgeons is working toward that end, but the other specialties simply refuse to recognize the need or to deny the possibility of laying down such guidelines. Medicine they say is not an exact science and is, therefore, incapable of being run by such guidelines. This is the typical reactionary response and it serves only to increase the area of misunderstanding between the public and the profession.

Something is being done, I am told, by many physicians. The President has appointed a committee to study the problem of malpractice and the HEW is cooperating with that committee. If any of you have seen the Ribicoff report, then you can take little solace in the hope that the HEW is going to solve your problem. And if you feel that the President's commission is going to do your work for you, I am afraid you are mistaken. The function of the President's commission is to alleviate the problems that affect the public, and to expand the bureaucratic influence on the medical profession. Lastly, there may be some crumb of aid thrown to the doctors. If this problem is going to be solved, it must be done from within the profession, and done with the aid of competent attorneys. Doctors are no more capable of legislation than they are of writing their own contracts. To paraphrase Osler, the doctor who legislates in his own behalf, or writes his own contract, has an ass for a legislator or an ass for a lawyer.

I am told by many of my fellow orthopedists that guidelines in the field of fractures in orthopedics are simply not realistic. If we haven't been teaching our students guidelines and fundamentals of the difference between right and wrong in handling of fractures, then I say we have been guilty of malfeasance; 80%, or more, of fractures can be handled following flexible guidelines.

In the days when we lectured to third-year students (and I refer to those as the good old days, because today the subject of fractures and trauma is an elective one for the students), the diagnosis, the mechanism, the pathology, the symptoms, the treatment, and the complication of all of the common fractures were taught. In discussing fractures of the hip, the students were told that in every patient in whom there had been a fall and complaint of pain in the thigh and in the knee that, even with the absence of deformity, one should suspect, in the middle-aged or elderly patient, a fracture of the hip, and that the hip should be X-rayed, as well as the thigh and the femur.

It was explained to the students that the nerve supply to the hip also extended to the adductor muscles which referred pain to the knee. In a recent case, an orthopedic surgeon saw such a patient, X-rayed the thigh and the knee, sent the patient home. The patient was seen again three days later with the same complaint. The knee and thigh were X-rayed. The patient was seen a third and fourth time; again, the diagnosis was missed; finally, about six months or more later, the diagnosis was made by another orthopedic surgeon. Certainly a Board orthopedic surgeon knew better, but he made a mistake. He simply developed a blind spot for that diagnosis, and overlooked it on every opportunity that presented itself. This was a clearcut mistake, and certainly this problem could be included in any guidelines of the diagnosis and treatment of fractures of the hip. This question has been asked of hundreds of candidates for Board certification, and on hundreds of examinations given to third- and fourth-year students. If we are to expect our practitioners to be aware of only the common findings, then certainly any general practitioner could do as well as the specialist. It is the uncommon, but not completely bizarre, finding that calls for the increased skill and training required of the specialist.

Lately, the county and city medical societies have appointed peer review committees. Part of their function is to help establish guidelines in the various fields of practice. These guidelines will be transmitted to the county, from the county to the AMA, and then from the AMA only the Lord knows where. What isn't recognized by the profession is that the states are doing away with the so-called local standard of care, and that they are recognizing that there should be a minimal standard of care on a national basis. Yet the courts continue to quote standards of care which, like a holy ghost, is simply never visualized.

Two important problems arise within the practice of industrial medicine. The first is failure to heed the directions of a drug insert. There are many examples of injuries from machinery and from driving while under the influence of an antihistamine or a muscle relaxant. Failure to call to the attention of the patient the inherent dangers of the drug and failure to warn of the dangers from use of a drug while working, particularly with dangerous machinery, may make the physician liable for damage sustained to the individual.

Secondly, it is customary in many patients with previous cardiac history to do preemployment physicals, as well as EKGs. It must be noted that a negative EKG is no guarantee of ability to cope with vigorous activity No physician should be a guarantor.

Where there is a finding of preexisting pathology, such as osteoarthritis and degeneration of the spine, how is the effect of an injury developed within the scope of the worker's employment to be evaluated? The industrial physician, if he is to evaluate the presence or absence of permanent disability and rate the individual, should be familiar with the literature. He should not pluck figures from the air, or simply tell the court that his great experience enables him to state, without equivocation, that this patient has no, or little, disability, or, on the contrary, is totally disabled.

Electrical injuries, within the hospital and within the industrial physician's physiotherapy unit, are more frequent than usually admitted. Some reports in the recent literature indicate that thousands of people are electrocuted because of faulty equipment. The use and misuse of sophisticated electrical equipment requires frequent inspection of wiring, of load capacities, and of the danger of overexposure by radiation to the patient. A physician, for example, who prescribes a specific type of electrical therapy which may give rise to a cardiac arrest should have someone available who knows how to handle cardiac arrests. The courts have held that he who holds himself out as an expert in the use of special equipment, or in the use of a special procedure must be able to look after the complications from such equipment or procedure.

The dispensing of drugs, such as penicillin to which the patient may be allergic, may leave the dispenser liable if he failed to make inquiries as to a previous history of sensitivity. It should be noted that many individuals without histories of penicillin allergies may develop immediate or anaphylactic reactions if penicillin is administered. In a study of ward patients and outpatients with no histories of penicillin allergies, from 4% to 9%, depending on age, had positive skin tests to Benzylpenicilloyl Polylysine. An initial prick test followed by an intradermal test in those who do not react to the prick test, is recommended (Reported to the American Academy of Allergy in February 1972).

The industrial physician has, in many respects, the same problems relative to litigation as has any other member of a specialized group. His problems may be somewhat more complicated in that he may be expected to cross several specialties and retain the same expertise as the individual specialist. The problem of negligence and litigation exists. It is not the brainchild of the law. It is a problem that is inherent in our society. It will not go away by demanding that the lawyers stop taking contingency cases, or by other negative approaches. The problem has to be met head-on by the medical profession.

We do make mistakes. We must prepare ourselves to make as few as possible. We must educate ourselves to understand the pitfalls of each specialty and, most of all, we must not develop a paranoia. It has not been proven that the practice of medicine has deteriorated or become completely defensive because of the threat of litigation, nor has it been shown that, after litigation, the individual physician's practice is endangered, professionally or economically, other than through the increase of insurance premiums. No fault insurance, by the way, will be no panacea. In effect, what no fault insurance will do, so far as malpractice is concerned, is to guarantee a perfect result, or else pay for what is less than that. We, as organizations and as individuals, must try to look at this problem objectively, and without too much emotion, to influence medical schools to improve the teaching of fundamental problems of trauma and to educate the students as to their medical-legal responsibilities.

The Williams-Steiger Occupational Safety and Health Act of 1970, now Public Law 91-596, was supported by the American Medical Association with the realization that the federal government alone has inadequate resources for administration or enforcement of the provisions. Only by efforts at community levels by business, labor, voluntary organizations, and health professions can the purpose of the Congress be readily implemented. Preventive medicine has a major role to play in these efforts. See *JAMA,* Feb 14, 1972, Vol 219, No. 7.

While most physicians have limited information concerning the various aspects of health and

occupational safety programs, the industrial physician, by the very nature of his background and interests, should be able to provide the expertise necessary in 1) surveying hazards at the work place; 2) providing teamwork with industrial nurses, safety engineers, industrial hygienists, and environmental testing laboratories; 3) diagnosis and treatment of occupational diseases; 4) selective screening examinations for placement of workers on jobs appropriate to their health status; 5) knowledge of exposure standards for chemical and physical agents hazardous to the worker; 6) medical evaluation of impairment of injured or convalescent workers returning to employment; 7) community rehabilitation resources and how to use them; and 8) reporting and recording systems for developing accident and disease frequency statistics, as well as epidemiology studies in an employee population.

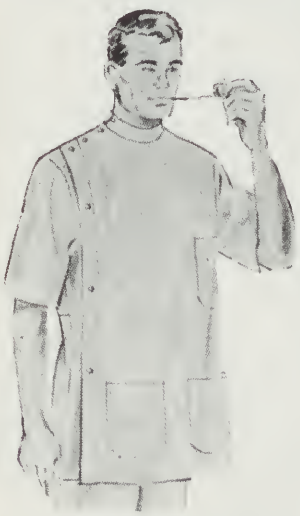
Among the more important aspects of the Williams-Steiger Act are the insistence that each employer furnish a work place free from recognized hazards by complying with occupational safety and health standards, and that the Secretary of Labor shall promulgate consensus standards adopted by standards-producing organizations assisted by the US Department of Health, Education, and Welfare.

The Williams-Steiger Act points out sharply the increased medical-legal responsibilities of the industrial physician, and implies that the role of the physician will be henceforth much more complicated.


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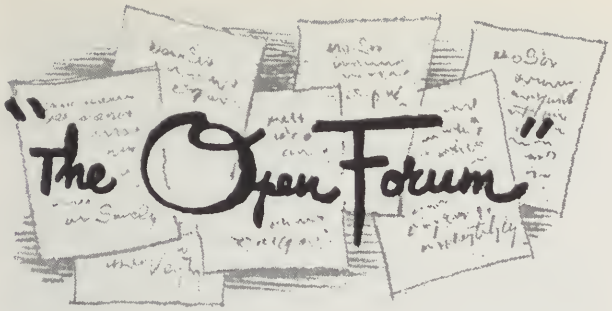
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## RELATIVE EFFICACY

*This editorial-article from the Pharmaceutical Manufacturers Association, 1155 Fifteenth St NW, Washington, DC 20005, attempts to answer the question: "When the Government decides what drug should be prescribed, is the patient better served?" The PMA invites your comments and suggestions.*

In the fall of 1971, several officials of the Food and Drug Administration began stating that drug manufacturers should provide information on the comparative usefulness of their medications in the treatment of specific conditions. Such "relative efficacy" data they said should be made part of the prescribing information supplied to physicians in drug product labeling.

To persons familiar with the history of the Food, Drug, and Cosmetic Act, the statements from FDA were far from novel. Indeed, the matter had been thoroughly discussed a decade before, when Congress was in the process of enacting the 1962 Amendments to the Act.

At that time, Abraham Ribicoff, DHEW secretary, stated unequivocally that those who had expressed concern that the new law might be



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used to permit the Federal Government to make relative efficacy judgments had "no basis for such apprehensions." The proposed amendments, he stressed, "would merely require a showing that the new drug described in the application is safe for use and is effective in use, under conditions prescribed, recommended or suggested, in the labeling thereof. This would not require a showing of relatively greater efficacy than that of other drugs. It would merely require that a drug claimed to be effective for a particular purpose had been demonstrated by sound scientific procedures to be effective for that purpose. In short, it must live up to the claims made for it."

When asked specifically if FDA wanted the power to decide relative efficacy, Secretary Ribicoff answered, "We do not seek it. We do not want it. And my testimony indicated we do not intend to pass on it . . . We do not want to pass on relative efficacy. We do not want to say that drug A is better than drug B or B is greater than C. We are not looking for that at all, and we do not think it is necessary."

It would be difficult to express a more clear-cut denial of any intention to act to determine relative efficacy than that of the former HEW Secretary. Yet it appears that a change in the Department's stated position is intended by some at FDA, apparently on the unsupportable grounds that drug labeling, which does not indicate the product's relative position on a therapeutic scale, is not fully informative, or is somehow false or misleading.

In order to follow that reasoning, one must assume that a prescribing priority system can be clearly established and, if so, that the Federal Government should be the judging agency.

And that is the crux of the matter.

The question of whether relative efficacy should be judged by the government is preceded by the question of whether it can be accurately determined. For some drugs, a consensus of expert opinion has been reached. In these cases, the less desirable drug has either vanished (bromides for anxiety, mercurials for diuresis), or has shrunk to prescribing levels justified by the advantages it retains (veratrum for hypertension, sulfonamides for infection). Results of this sort do not require government intervention. On the contrary, it may well be that attempts to impose consensus by fiat rather than by scientific and professional interaction would have had a counterproductive effect.

That leaves many areas of therapy and many groups of drugs for which a consensus has not been reached. Can the government line up, for example, all of the drugs in use against high blood pressure, and meaningfully arrange them in order of efficacy? If so, the physician's task could be simplified immensely.

But the answer to this question is no.

A number of controlled studies have failed to show any significant difference in efficacy between the major antihypertensive drugs. Yet, while the experts in the field and the prescribing physicians may be at odds not one seems to claim that the major antihypertensive drugs now available are indistinguishable with respect to efficacy or usefulness.

While informed experts decline to make arbitrary judgments about the order in which particular drug products should be used, legislation is now pending (S. 2812, 92nd Congress) that would prevent the marketing of any drug not proven to be better than those already available. Had this bill been in effect when the first thiazide diuretics reached the market, it seems likely that only a handful would be available. Researchers, encouraged to proceed even if their discoveries were only modest, found more than a dozen such products, offering the physician a broad range of activity to meet his patient's needs. And, the availability of these alternatives has doubtless been a factor in the reduction — by about 15% at wholesale — in the price of the average diuretic.

It is thus impossible to justify the relative efficacy requirement from an economic point of view, let alone a medical one.

It is noteworthy that early tests of a drug often fail to uncover some of its best advantages. Examples:

1) Early research on dimenhydrinate was directed toward its antihistaminic properties; only late in the program was another of its characteristics—its usefulness against motion sickness —noticed.

2) The first research using the phenothiazines was in sedation; the drugs' cardinal value in psychoses came to clinicians' attention later.

3) Again, the value of isoproterenol in shock, of mafenide acetate in burns, and of lidocaine in cardiac arrhythmia, were not recognized for years after their widespread use for other, less important medical indications.

Had FDA taken the shortsighted position then that one or two good drugs for each therapeutic need should suffice, the drugs just mentioned might never have been marketed; FDA could have said, in each case, that still another anti-

histamine, another sedative, one more cardiac stimulant, yet another topical antibacterial, and another local anesthetic — was not needed.

Because FDA did not make such arguments when these drugs were before them for approval, hundreds of thousands of patients have benefited enormously, in many cases to the extent of recovering the chance to live.

Similarly, there is a difference of medical opinion on the value of antihistamines, corticosteroids, and sympathomimetic agents against allergy, with no clearcut consensus on the issue. A lack of unanimity also exists with respect to the therapy of peptic ulcer, where anticholingergics and antacids are used, and in various musculoskeletal conditions, where some advocate muscle relaxants and others order only phenobarbital, much depends on the particular patient.

In such cases, FDA traditionally has followed the lawfully required and prudent course of letting the relative merits of the drug be found through experience, once the general questions of safety and efficacy have been answered. The National Academy of Sciences/National Research Council's 1969 Drug Efficacy Study commented on the point:

> "The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."

That process has been responsible for the large array of steroids of value on contraception, for example, and for the development of new drugs for the management of gout and diabetes. In each of these areas, seemingly trivial differences in the drug not infrequently make major differences to patients — and make arbitrary relative efficacy judgments impossible.

Even in the case of the antibiotics, where it is often assumed that it is easy to match the medication against the disease, it is not uncommon to find authoritative disagreements as to the drugs of first choice (or second and third for that matter).

It must be borne in mind that the physician is not only dealing with a disease, which may follow a varied course, but also with an individual patient, whose reactions to the drugs prescribed may be crucial to the outcome of the therapy. Because the individual patient's reactions can make it dangerous to give him what for most patients is the "drug of choice," the physician must be permitted freedom to use his own judgment.



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If there is a difference of expert opinion and a need for flexibility in the selection of antibiotics, that need is doubly evident in the selection of many other modes of therapy, where the causative agent or factors may well be less clearly understood, and the characteristics that distinguish one useful drug from another may be considerably less discreet. In the treatment of psychotic disorders, for example, it is widely acknowledged that the relative value of one major tranquilizer as against the others cannot be determined in advance, even though these agents have been under careful and aggressive study for more than 20 years.

Recent research in pharmacology indicates that there may well be a sound scientific foundation for recognizing the full importance of the use of skillful case-by-case judgment that cannot be performed by experts or authorities absent from the patient-doctor transaction.

The four main factors in a therapeutic relationship are: (1) Physician prescribes (2) drug against (3) disease of (4) the patient. The notion of relative efficacy assumes that for a given disease (factor 3), drugs can be ranked independent of physician (factor 1) and patient (factor 4). This assumption is false. Recent discoveries suggest that the individuality of the patient, and of the physician, play very important role in determining the effectiveness of drug treatment.

There is a real question as to whether the cost of designing meaningful, definitive studies would be even remotely justified by the patient benefits to be expected. In most therapeutic classes, the number of distinct drug entities of value in treating a particular condition is small, frequently less than a dozen. Broadly speaking, the pharmacological effects of the group can usually be described, as is done in any of the standard texts of therapeutics. Using this information, and adding his own background and experience, the physician chooses one compound, basing his choice on the particular therapeutic (or economic) qualities it offers his patient.

Rather than expend limited clinical research resources testing one well-known drug against another, the prudent use of those resources clearly lies in the development of entirely new compounds.

Meanwhile, information on the relative place of marketed drugs, weighing their therapeutic indexes against alternate therapy, is being collected and published in the usual ways. Better data on the overall ratio of desired effects to unwanted ones, which characterizes a given group of compounds when used in a particular situation, assist the physician, not merely in choosing a given drug, but also in selecting from alternative classes of compounds of possible value to the patient.

The provision, by their peers, of information for physicians' guidance is, of course, a far different thing than the provision of even the same information by the federal government, whose "guidelines" more often than not carry the force of law. The question naturally arises: What does it mean when the government — as distinguished from a private body or expert — asserts that Drug A is the one of first choice in Condition A? What is the physician's legal position if, on the basis of his personal experience and educational background, he responsibly disagrees?

The question has been raised many times, and in various ways. Over the years FDA officials have challenged distinguished clinicians and practicing doctors who openly advocate usage of prescription drugs in conditions and at dosage levels not indicated in the FDA—approved labeling.

In 1970 FDA Bureau of Drugs Director Henry Simmons, MD, advised doctors that whenever they intended to prescribe a medication for use in a manner not approved in the official FDA labeling, they should first file a "Notice of Claimed Investigational Exemption for a New Drug" form.

AMA's Department of Drugs objected vigorously, fearing that "the FDA proposes to approve, forbid, monitor, collect, collate, evaluate, and disseminate results of all clinical experience with drugs in this country that is not consistent with package insert recommendations, regardless of the agency's statutory jurisdiction . . . We believe the FDA should devote full attention to meeting its statutory obligations, not attempt to expand its statutory grant by regulating the practice of medicine."

AMA stressed that "the physician should always remember a subtle but important distinction: The FDA has no legal authority to approve the uses of marketed drugs; it approves what a manufacturer may say about these uses in its labeling and advertising." Earlier, AMA had published its belief that "the package insert is part of the labeling of a drug and not a legal restriction on the thoughtful and careful use of a drug by an informed physician ."

That "subtle but important distinction" has never been acknowledged by the FDA, however, and increasingly, in liability actions brought against physicians, failure to adhere to the labeling recommendations is being portrayed by

medical malpractice lawyers as ipso facto evidence of wrongdoing. Recognizing this, the American Academy of Family Physicians, in an April 7, 1972 letter to FDA, said that relative efficacy judgments in government-approved labeling would carry the threat of "implied police power, if in no other way by the threat of such regulations being used as a 'club' in malpractice suits." The Academy, which represents 31,000 family physicians, urged that FDA abandon any plans to require relative efficacy statements.

It is the general rule for FDA to interpret its regulatory powers very broadly; it may therefore be assumed that some agency personnel might deem it necessary for a "properly labeled" drug product to include relative efficacy information. It is imperative that the professions, the pharmaceuticals industry and the public be alerted to the dangers of any official action or unannounced application of such a position by the Food and Drug Administration.

There must be general recognition that labeling requirements by FDA in the area of relative effectiveness, to the extent that they are given medical and juridical recognition, would represent a fundamental new departure for American medicine, under Federal control, unlike that found in any other national system. In the end, much will depend on how effectively physicians and consumers express their desire to avoid bureaucratic control of this sort, and how well they demonstrate that such procedures do not serve the public interest.

## Baltimore County Medical Association

The Baltimore County Medical Association held its October meeting at the Holiday Inn, Cromwell Bridge Road, Towson, on the 18th.

The meeting was well attended. Following luncheon, the Peer Review Committee gave a report on the kinds of cases it has received. Following the presentation, a question-and-answer period was held.

The Association celebrated its 75th anniversary on November 4 with a luncheon, afternoon seminar, cocktail party, and dinner. All events were held at the St Joseph Hospital in Towson. Members and spouses attended.

The annual meeting will be held on December 20 at Peerce's Plantation. New officers will be installed at that time.

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# Eduard Jaeger Ritter Von Jaxthal, 1818-1884

The latest addition to the library's historical collection is the W B Saunders Company's new edition of **Jaeger's Atlas of Diseases of the Ocular Fundus.** The accuracy of Jaeger's hand-drawn and painted illustrations makes this atlas a classic in the field of ophthalmology. Prior to the new Saunders edition, these paintings were virtually unavailable to modern-day physicians.

Jaeger began work on his atlas in 1851, shortly after the invention of the ophthalmoscope by Hermann von Helmholtz. His 184 pictures, illustrating the ocular fundus in a variety of conditions, were produced with minute exactness. According to Jaeger in the preface of the 1869 edition of his atlas, each picture required between 20 and 40 sittings, of from two to three hours each, to prepare the sketch for the image alone. Regarding the exactness of the completed pictures, Jaeger said:

"Not a line has been added voluntarily in any of the pictures, nor have any of them been prepared only approximately like the original. Every physiological and pathological appearance, each individual deposit of pigment, etc, which appear in the picture have been reproduced in their natural size, form, color, position, and mutual relation to each other and with regard to every separate angle and to the smallest detail, etc, exactly as I saw them and was capable of reproducing."

Some of Jaeger's paintings were published in a limited edition of volumes entitled **Beitrage zur Pathologie des Auges.** The figures in the various editions of the more familiar **Ophthalmoskopischer Hand-Atlas** are often only poor approximations of the originals, and fail to convey the brilliance of Jaeger's color paintings. This atlas has been long out of print and unobtainable.

Following Jaeger's death in 1884, William Fisher Norris, Clinical Professor of Diseases of the Eye at the University of Pennsylvania, purchased Jaeger's paintings for $2400. Norris had studied under Jaeger in Europe. After Norris' death in 1901, the paintings were bequeathed to the College of Physicians of Philadelphia. In 1963 the paintings were made available for the enlarged and updated edition by Daniel M Albert, MD.

The Medical and Chirurgical Faculty Library's historical collection houses three of Jaeger's works, including two early editions of his atlas. **Uber die Einstellung des dioplrischen Apparates in menschlichen Auge,** published in Vienna in 1861, contains 38 black-and-white figures drawn by Jaeger and lithographed by Dr A Elfinger. **Ophthalmoskopischer Hand-Atlas** was the first edition of Jaeger's most inclusive work. It contains 29 color plates, with 128 figures. The text contains Jaeger's commentary on each figure as well as his histories on the patients who sat for the paintings. In 1870 Jaeger collaborated with Louis de Wecker in Paris and through their **Traite des Maladies du Fond de L'Oeil et Atlas D'Ophthalmoscopie** made his reproductions available to French medicine.

The new edition of Jaeger's Atlas is prefaced with an excellent historical introduction regarding the invention of the Ophthalmoscope, and the work of Jaeger and Norris. There is also a bibliography to this historical introduction.

The new atlas and the three earlier works of Jaeger can be examined at the library. These are currently part of a display on the history of Ophthalmoscopy.

JOSEPH E. JENSEN
Assistant Librarian

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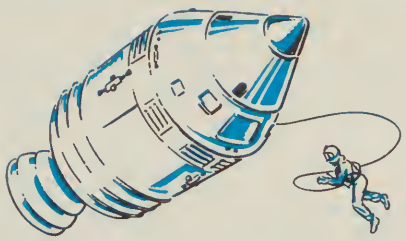
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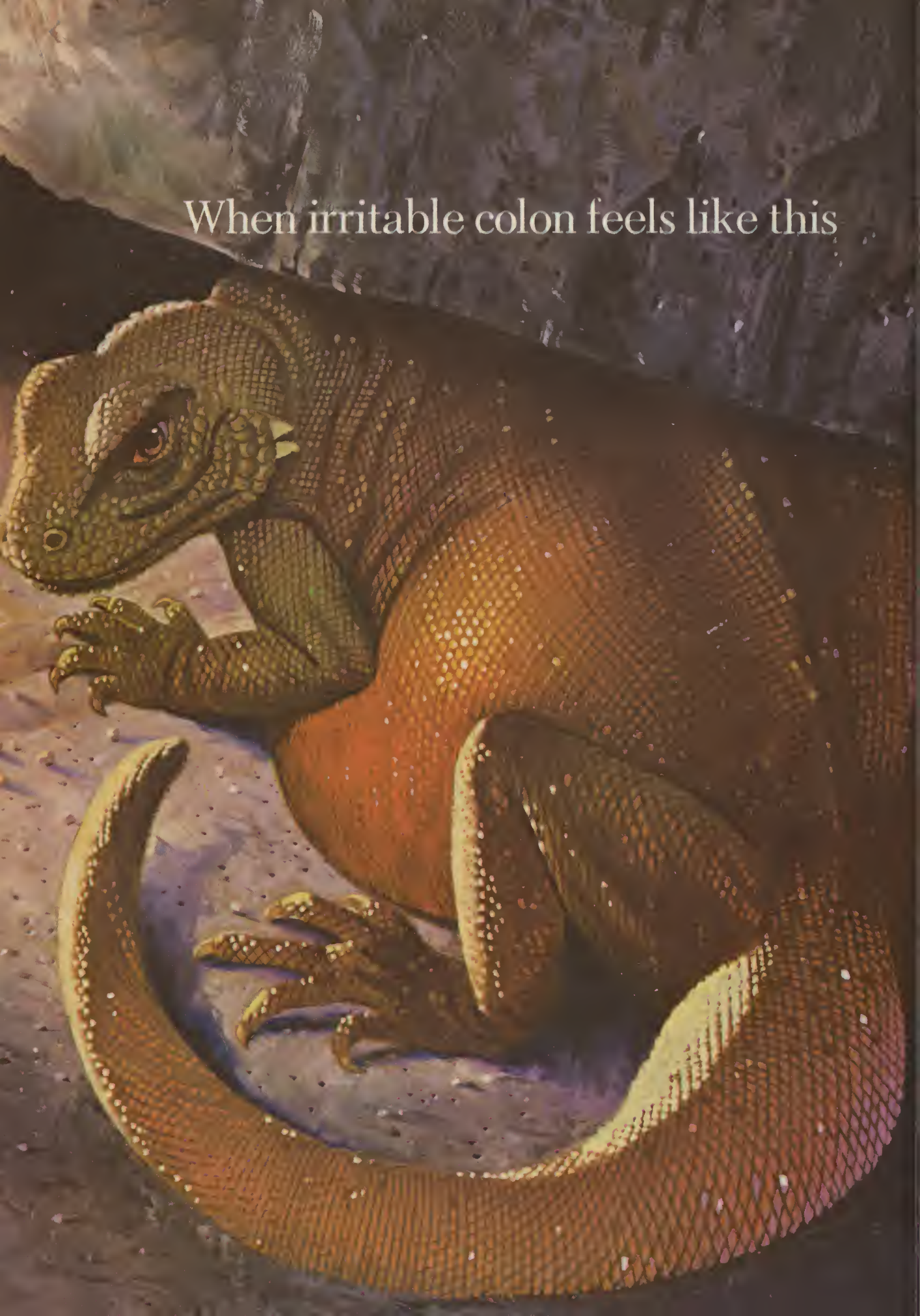
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# FINAL REPORT ON THE TB TESTING PROGRAM

**CONNIE SAWYER, RN**
**Chief Nurse, TB Testing Project**
**For the TuberculinTesting Study Committee**

On June 16, 1969 a Tuberculin Testing Program was instituted at the Maryland Tuberculosis and Respiratory Disease Association in conjunction with the existing X-ray Screening Program. This demonstration was aimed at determining what portion of the approximately 25,000 apparently healthy individuals reporting to the Center annually would react positively to the standard tuberculin test. The program was further aimed toward the continuing education of the private physician, to encourage greater use of the tuberculin test in his office practice, and to point up the need for and benefits of chemoprophylaxis in positive reactors.

During the entire program, the same three nurses did the injecting and reading. Our Medical Director was present in our Center three times weekly, and was readily available at all other times. The standard Mantoux technique was the method used for injection.

Patients represented a wide, cross-section of the population. There were a large number of teachers, college students, industrial workers, and laborers. Almost one third of the patients were referred to us by private physicians as a part of the patient's routine yearly physical. In addition to these sources many patients were self referrals.

The referral methods used in the testing center were as follows: Regardless of how the patient reached us originally, anyone with a positive skin test was referred to their private physician and in the absence of a doctor they were referred to the City Health Department or to one of their home county health departments. The health department in the area followed up by either checking to see which patients had been placed on chemoprophylaxis by private physicians or placing the patients on medication themselves.

At the inception of the program the tuberculin test was entirely optional. Patients were approached, the test explained, and the decision to be tested was made by the patient. Only 27% of the patients X-rayed during the first six months accepted the skin test.

After the initial six months, the tuberculin test became an integral part of the screening program. All patients entering for X-rays were given a skin test unless they specifically declined or there was some medical indication that it should not be given.

In the beginning commercially prepared tuberculin was used. Because of the low percentage of positive reactors, in an area where a high percentage could be expected, a question was raised by the committee regarding the accuracy of the solution. After September 1969, all tuberculin used was supplied by the US Public Health Service.

When it became apparent that a small percentage of patients were returning to have their tests read in person, it also came to our attention that many others were calling us on the telephone to tell us they could not return, but there was "nothing at all" on their arm. The committee approved the reporting of such calls as negative reactions, although we all realized that this could not be considered 100% accurate. If the reports sounded questionable at all, we asked the patient to return in person. This approach met with a great deal of success, as evidenced by the accompanying statistics. The majority of patients questioned by telephone did indeed have positive reactions.

An effort to contact the patients who had not returned for a reading had been made for sev-

eral months. This procedure was not successful and was abandoned. The majority of our patients were employed and could not be contacted at their jobs. The procedure was extremely time consuming, considering that no appreciable returns were realized.

In an effort to follow up possible converters, postcards were sent to all patients with 5-to-9mm reactions, asking if they would return in six months for a skin test. This procedure was not successful in terms of the numbers of patients responding. Of the patients who returned for both skin test and reading, 47% had converted to reactions of 10mm or more.

After February 1971, it became evident that there was an appreciable increase in positive reactions and highly positive reactors above 20mm. This was ultimately attributed to the use of Tween 80 in the tuberculin being used.

Worth mentioning, due to the enormous success of the program, was the community project done in association with the Gardenville Lions Club and the City Health Department. The program lasted for 12 days, injecting being done for ten days. During that time 5,316 skin tests were administered and an unprecedented 93.99% of those persons injected were read. Of that number 241 positive reactors were found.

In conclusion it was generally felt by the Evaluating Committee that there had been some inroads made in the area of education of the private physicians. This was particularly true of

**Table 1: Report of Positive Reactors by Age and Size of Reaction (January 1971-March 1972)**

| Age | 10-14mm | 15-19mm | 20+mm |
|---|---|---|---|
| 10-14 | 3 | 0 | 0 |
| 15-19 | 24 | 19 | 8 |
| 20-24 | 50 | 50 | 45 |
| 25-44 | 220 | 301 | 261 |
| 45-64 | 267 | 340 | 286 |
| 65+ | 60 | 58 | 48 |
| **Totals** | **624** | **768** | **648** |

The total number of positive reactors in this time period was 2,040. Of this number, 754 patients were started on chemoprophylaxis.

**Table 2: Total Statistics 6/16/69-3/30/72**

| | | |
|---|---|---|
| X-rays taken | 67,455 | |
| Skin tests given | 33,920 | (50% of X-ray patients) |
| Skin tests read in person | 13,818 | (40%) |
| Patients who called in negative readings | 9,160 | (27%) |
| | 22,978 | 67% |
| Readings 5-9mm | 834 | ( 6%) of 13,818 |
| Readings 10mm and above | 3,760 | (27%) |
| Positive skin test readings c positive film | 98 | |
| Dr referrals c presc | 4,961 | |
| Dr referrals s presc | 5,350 | |

Positive X-ray and/or positive skin test reports sent to City Health Depts 4,020
Positive X-ray and/or positive skin test reports sent to County Health Depts

| | | | | | |
|---|---|---|---|---|---|
| Baltimore: | 752 | Howard: | 25 | Montgomery: | 4 |
| Anne Arundel: | 217 | Harford: | 10 | Prince George: | 16 |
| Frederick: | 1 | Carroll: | 13 | | |
| Out of State: | 5 | | | | |

**Number of patients who were asked to come in following a questionable telephone report-records kept as of 2/11/71**

| | |
|---|---|
| Called in: | 537 |
| Returned in person: | 438 |
| Positive reactors: | 346 |
| Reactions 0-9mm: | 80 |
| Did not return: | 99 |

**6-month recall report**

Postal cards sent: 801
Patients who returned: 309
Reactions 0-9mm: 78
Reactions 10mm and above: 121
Patients who did not return for reading: 51
Patients who did not return for test: 492

the younger men in practice. There was some resistance from a very few well-established physicians in the area, both from the testing standpoint and in the use of chemoprophylaxis. For the most part these few physicians preferred to do the test in their offices.

Our goal of identifying a large number of positive reactors in the community was met successfully.

If such a program was to be instituted in the future it seems that it might be wise to eliminate those procedures which proved unsuccessful in this instance. The end result could be even more satisfying if a way could be found so that a greater number of patients could have their skin tests read.

## American Association of Medical Assistants

The 12th Semiannual Meeting of the American Association of Medical Assistants-State of Maryland was held at the Sea Scape Motel, Ocean City, Md, September 16.

In sequence, the program consisted of registration, coffee break, business meeting, luncheon, auction, "Focus on Medical Rehabilitation" panel, awarding of door prizes, adjournment, and banquet. The banquet invocation was given by Rev Thomas Subock; John B Littleton, MD, was the master of ceremonies.

Stephen Hiltabidle, MD, advisor to the Anne Arundel AAMA Chapter, was the lead-off panelist in the afternoon seminar on "Focus on Medical Rehabilitation."

Dr Hiltabidle's presentation concerned the cancer patient. He emphasized that trust was the most important factor for good rapport between the doctor and the patient. He said that, although it is hard to tell the truth of a cancer diagnosis, it is the only way in dealing with 99% of the patients.

It was his opinion that most people today are too intelligent to accept a false diagnosis and that fear causes delay in the proper treatment. He concluded that the American Cancer Society and colostomy clubs give tremendous help to cancer patients.

The next panelist, John B Littleton, MD, AAMA advisor for Maryland, discussed low back pain. This is as much of a problem as a headache, he claimed, and is commonly experienced from injuries arising from contact sports, accidents, and surgery. Correct posture and a regulated program of exercises to improve flexion of the back muscles often relieve the patient of pain, he explained. He concluded that when this program was followed the number of patients requiring hospitalization for disc problems decreased greatly.

He was followed by Antonio Rivera, MD, a private pediatrician in Anne Arundel County and treasurer of the Anne Arundel County Medical Society.

Dr Rivera spoke about the mentally retarded handicapped child. He predicted a tremendous change in the next five to ten years in the treatment of the mentally retarded child. He forecast that such treatment, now in the planning stage, would be mainly in the home instead of an institution. He indicated a need for social life and an adequate amount of exercise for such children. Most, he said, experience sleeping problems which should not be treated with sedation but with more physical exercise during the day to encourage sleep at night.

The auction of handmade articles netted $62 and was conducted by Rita Cobry with Dorothy Hartel serving as cashier. This added a fun feature to the meeting — and money, too!

RITA COBRY, CMA
Publicity Chairman





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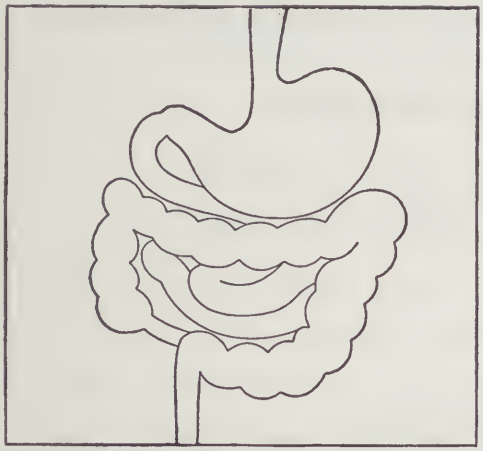


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APRIL 25, 26, 27, 1973

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Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the **Baltimore Civic Center** on

**APRIL 25, 26, 27, 1973.**

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## APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

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1. Title of exhibit: .....

.....

2. Please attach a 50-100 word description of the exhibit: .....

3. Give amount of space required, depth, width, and height: .....

If exhibit has side panels, are depth and width included above? .....

If not, what additional space is required? .....

4. Electrical or other requirements: .....

.....

5. Has exhibit been shown at other medical meetings? .....

.....

6. Name and title of exhibitor: .....

.....

7. Name of institution cooperating in the exhibit: .....

.....

8. Address of exhibitor: .....

.....

## RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

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2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 500 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
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# Present and Future Status of Telemetry In Emergency Medical Services

EUGENE L NAGEL, MD
University of Miami School of Medicine
Miami, Florida 33152

The concept of an ambulance technician needing medical consultation and advice has been slow to evolve. The history of the ambulance technician has been one of separation from the medical (ie, doctor and hospital) system. Only recently has there been participation by doctors in their training[1] and in the creation of standards of both equipment[2] and performance of duties.[3] There still is a reluctance on the part of the medical profession to actively supervise, consult, issue direct medical commands, and participate in the moment-to-moment operation of these emergency care systems. This reluctance is gradually being overcome by the demands of an improving emergency medical service and by the relative ease by which modern communications can link the emergency medical technician in the field and the physician, whether hospital-based or mobile.

Telemetry, in its strictest sense, means "measuring at a distance." Space technology has led us to think of multiple channels of data and continuous recording. Emergency medical communications, however, are designed for episodic incidents, generally short in duration, and require quantums of analog, as well as objectively and subjectively descriptive information. About the only analog signal currently used is the single-lead electrocardiogram, ie, a rhythm strip. Objective data is transmitted by voice, as is the case with vital sign information. Finally, the prior medical history and acute event description again is by voice transmission. We might characterize a typical incident as one to two minutes of voice data and perhaps 30 seconds of electrocardiogram. This data then leads either to a diagnosis and recommendation for treatment and/or transport, or to further data gathering. This then brings the doctor into the emergency treatment chain just as in the case of a hospitalized patient, the charge nurse on the floor, and a communications channel link (in this latter case, the telephone).

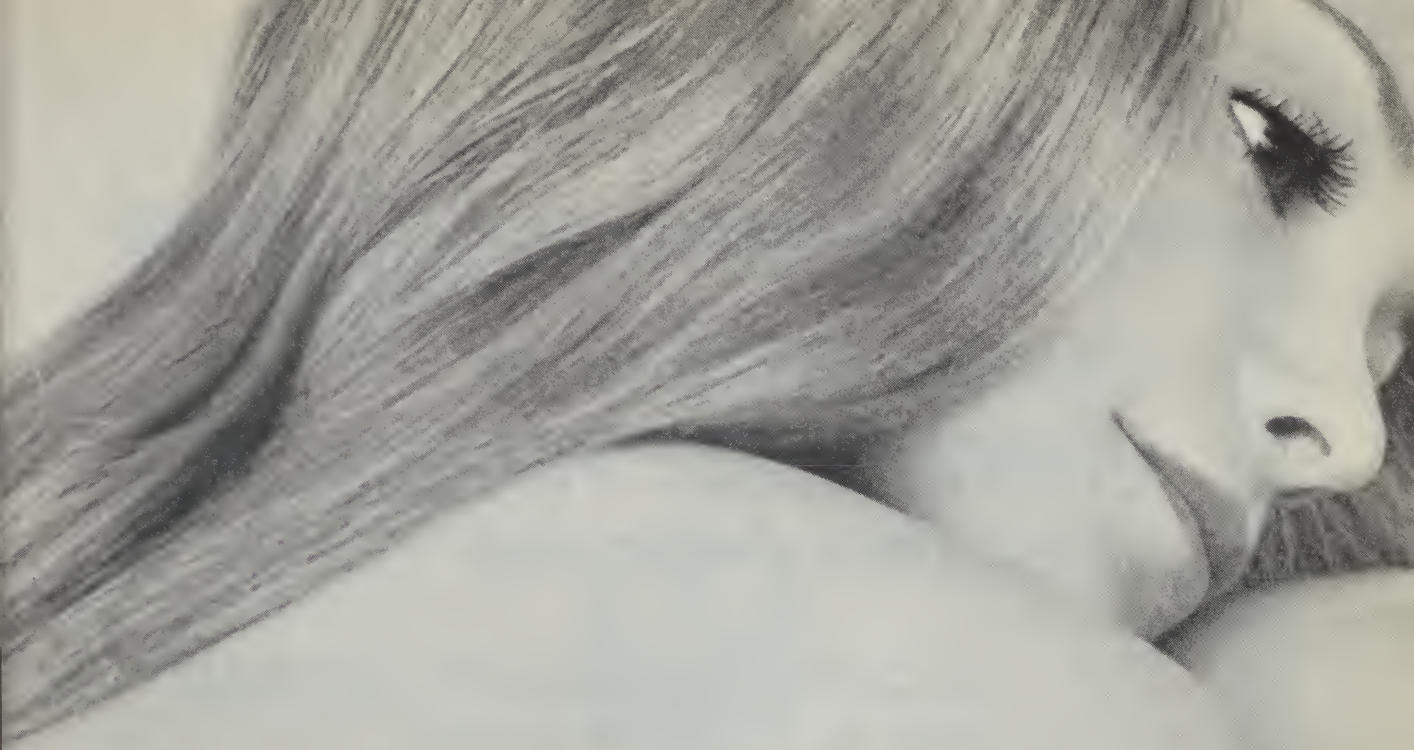
We would like telemetry systems to combine the two modalities: analog, and voice data transmission. The equipment necessary for the provision of this service is "off the shelf" and available. Radio transceivers combined with signal conditioning equipment are available, as are elaborate hospital display consoles. The intricacies of land-mobile radio networks are being searched for solutions to the interconnection of the hospital, rescue vehicle and paramedic dispatcher, and physician. Recent changes in Rules by the Federal Communications Commission[4] have given emergency medical services their own telemetry and associated dispatch channels in the ultra-high frequency range. Although the number of present telemetry systems in operation is probably less than 25, the prospect is for many hundreds in the near future. The emergency medical communications systems in continuous functional use may, for the first time, offer a practical solution to the need for emergency medical communications in time of large-scale emergencies.

The increasing demand for instantaneous medical consultation in emergent situations may provide further impetus to the regionalization of emergency care systems and integration of communications systems. Hard wire and microwave trunking facilities allow such a possibility over local areas, while satellite-provided channels may increase this capability over multi-state systems.

In summary, telemetry is but a part of emergency medical communications. The all-important element is the provision of a communications channel between the mobile emergency care team and the fixed or mobile physician. In the urban area, the physician usually is hospital-based, while in the rural area he is more often mobile. His direct involvement is the key to good emergency medical care.

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4. Published March 29, 1972.



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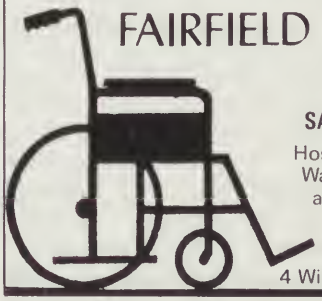
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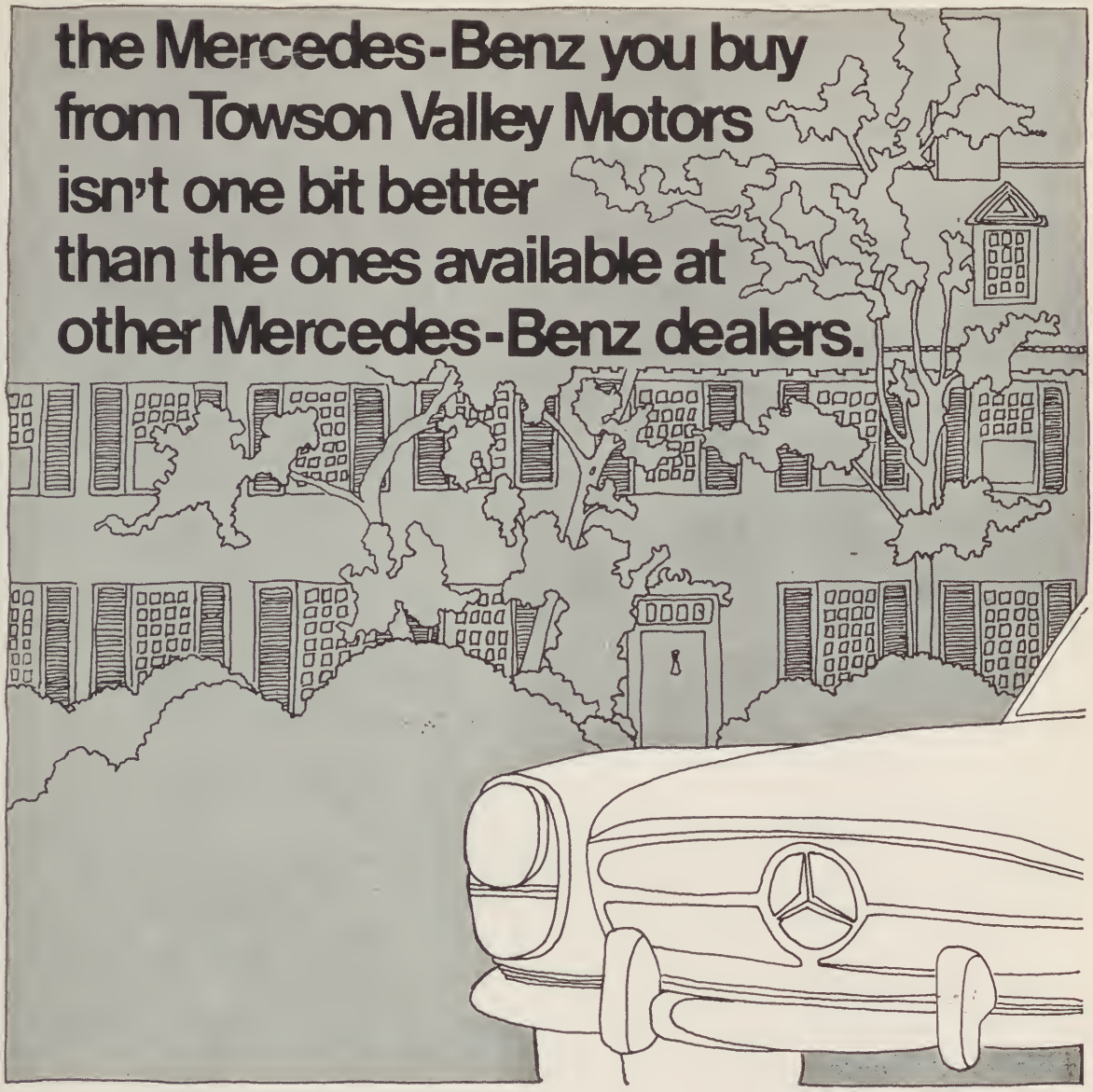
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